

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-6. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08732					
1. DECEASED-NAME (Type or Print)										2a. DATE KNOWN OF DEATH		2b. HOUR			
Ernest Eugene Abrams										DATE MATED <input checked="" type="checkbox"/> 6-24-69		14:40pm M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		Negro		4 March 1907		46 62YRS.						6 Month 24 Day 69 Year		19 4:50pm M	
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH			
Maryland				U.S.A.								Prince George's Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince George Hospital				Wood Work				None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Prince George's				Upper Marlboro				YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 483, Peerless Ave.	
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last									
Daniel Abrams						Agnes Cooley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No						212-14-5859		Frank Smith Box 483 Upper Marlboro, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u>												over 2 mo.			
150X DUE TO, OR AS A CONSEQUENCE OF Carcinoma of esophagus												over 2 mo.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				19 P.M.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				6-24-69							
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)							
Riverdale, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. (City or Town) (County) (State)					
Burial				6-28-69		Moses Cemetery				Arundel, Co. Maryland					
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Rollins Funeral Home, Inc. 4339 Hunt Pl. N.E. Wash., D.C.										JUL 2 1969		Charles Judge			

FOR STATE HEALTH DEPT.

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08739

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08733

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month Day Year				2b. HOUR	
Woodrow			Jennings			Adams				6-14-69 19:55am	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	3-28-1913	56 YRS.					Month 6 Day 14 Year 69		198:26am M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Va.			U. S. A.						Prince George's Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Electrician			Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Prince George's			Riverdale			6108 Longfellow Street		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Ellis			Adams			Bessie			Abshire		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			WW II			231 05 5089			Anita M. Adams Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4123 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Kehoe</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				6-15-69			
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			6/18/69			Evergreen Cemetery			Roanoke Roanoke Va		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons Hyattsville, Maryland						JUN 19 1969			<i>Charles Judge</i>		

Editor, The Journal of the American Medical Association
Chicago, Ill.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,
Yours very truly,
J. H. T. [Signature]

Enclosed for you are two copies of the report of the committee on the subject of the proposed change in the name of the Association.

I am, Sir, very respectfully,
Yours very truly,
J. H. T. [Signature]

Enclosed for you are two copies of the report of the committee on the subject of the proposed change in the name of the Association.

I am, Sir, very respectfully,
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

08740

Items #14, 15 & 13 taken from birth cert.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08734

1. DECEASED-NAME (Type or print) Baby			First Middle Last Female Anthony			2a. DATE OF DEATH Month Day Year June 1, 1969			2b. HOUR 12:15P		
3. SEX Female			4. RACE Colored			5. DATE OF BIRTH 06-01-69			6. AGE (In years last birthday) YRS. MONTHS DAYS 2 15		
7a. BIRTHPLACE (State or foreign country) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Prince Geo.			13c. CITY OR TOWN Washington, D.C.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 6005 Eastern Ave.			13f. STREET AND NUMBER 1538 Brook Street			13g. STREET AND NUMBER 6005 Eastern Ave.			13h. STREET AND NUMBER 1538 Brook Street		
14. FATHER'S NAME First Middle Last Phifer Edward Anthony			15. MOTHER'S MAIDEN NAME First Middle Last Lucille Cecelia Justbuddy			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		
17. INFORMANT Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature baby.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ruptio placenta.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>toxemia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from <u>June 1, 1969</u> , to <u>June 1, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 1, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ricardo Scartascini</u>			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type) Ricardo Scartascini, M.D.			22e. ADDRESS Prince George's General Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 6/7/69			23c. NAME OF CEMETERY OR CREMATORY Prince Geo. General Hosp.			23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland		
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator			25a. REC'D BY REGISTRAR DATE JUN 10 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

D. S. ZIL'BERMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08741		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08735					
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Tony		Astore						June Month 10 Day 69 Year		9:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN	
Male		White		Sept. 16, 1891		77 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Italy		USA				Prince Georges					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Tuxedo		2303 57th Avenue		Electrician		Electrical Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Pr. Geo.		Tuxedo				2303 57th Avenue			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Angelow		Astore						Mary		?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		Tuxedo, Md.			
WW I yes		578-26-2594		Alice Astore		2303 57th Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
3480				Amyotrophic Lateral Sclerosis				15 months			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from		Sept. 1968, to June 10 1969, that (I) (we) last saw the deceased alive on June 10 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		Ermo P. Inge		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		June 19/1969	
22d. PHYSICIAN'S NAME (Type)		Ermo P. Inge		22e. ADDRESS		1905 Queens Chapel Rd. Avondale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6/13/69		Ft. Lincoln		Colmar Manor P.G. Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Francis Gasch's Sons		Hyattsville, Md.		JUN 17 1969		[Signature]					

08741

WATERBURY, VERMONT
JANUARY 10, 1900
TO THE
HONORABLE
COMMISSIONER OF THE LAND OFFICE
MOUNTAIN VIEW, VERMONT
SIR:
I have the honor to acknowledge the receipt of your letter of the 7th inst. in relation to the above described land, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours,
J. H. [Signature]

Very truly,
J. H. [Signature]
J. H. [Signature]
J. H. [Signature]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Part 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08742

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08736

1. DECEASED-NAME (Type or Print) First Middle Last Edgar Leon Atwood			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-8-69 197:30pm			2b. HOUR				
3. SEX Male	4. RACE White	5. DATE OF BIRTH 3/22/1900	6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS 2 DAYS 16	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 6 Day 8 Year 69 198:46pm M			2d. HOUR	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Hillside		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1317 52nd. Ave.	
14. FATHER'S NAME First Middle Last John S. Atwood			15. MOTHER'S MAIDEN NAME First Middle Last Amelia Norris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-10-5705A		17. INFORMANT Mary I. Atwood-wife- same 13			ADDRESS#			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head 955x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year 7:30pm 6-8-69 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot self at home					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home			21f. LOCATION Street or R.F.D. No. same as #13		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John Kehoe			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6-9-69		
EXAMINER'S NAME (Type) John Kehoe M.D. Riverdale, Md.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/12/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Prince George's County, Md.				
24. FUNERAL DIRECTOR Tyson Wheeler				ADDRESS Funeral Home 1331 Rock. Pike Rockville, Md.		25a. REC'D BY REGISTRAR JUN 11 1969		25b. REGISTRAR'S SIGNATURE K. J. Judge		

DATA

(VI)

08743

CERTIFICATE OF DEATH

08737

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Margarete			Baranek			June 19, 69			M		
3 SEX		4. RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS. HOURS MIN	
Female		White		July 8, 1887		81 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Germany		U S A				Prince George Md					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Hyattsville		Sacred Heart Home		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER					
Maryland		Pro George's		Hyattsville		5805/ Queens Chapel Road					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Henry			Schad			Louise Grab					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Address					
no			228-62-6939			Sacred Heart Home, Hyattsville, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease & Congestive failure</u>										30 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) <u>Arteriosclerotic heart disease</u>										3 years	
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> , 19 <u>69</u> , to <u>6-19</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-19</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Thomas F Collins MD</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>6-19-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>						22e. ADDRESS <u>2600 Queen Chapel Rd</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		June 23, 1969		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u> ADDRESS						25a REC'D BY REGISTRAR <u>JUN 23 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

08744

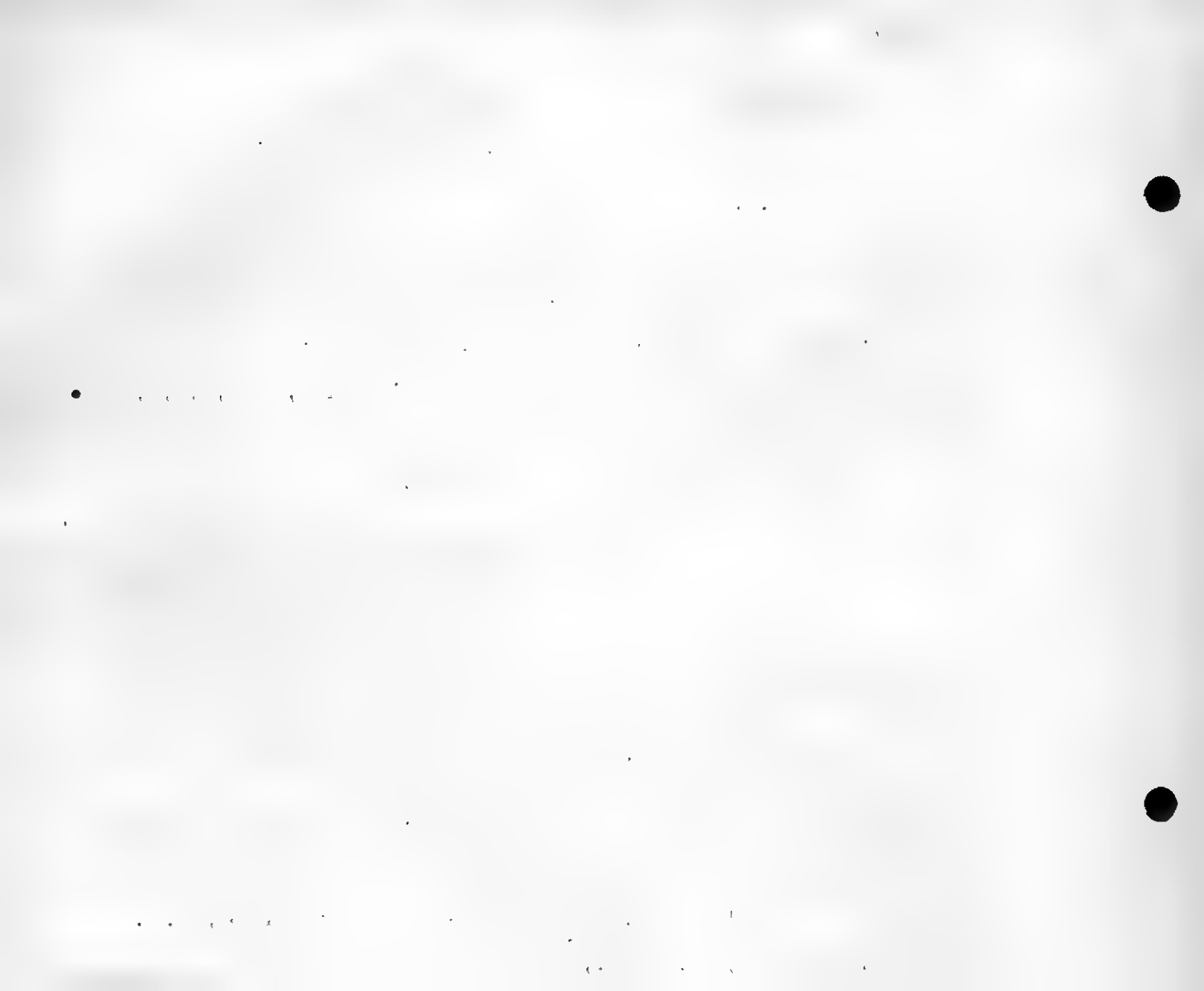
08738

1 DECEASED NAME (Type or print) Salvator e Barbagallo			2a DATE OF DEATH Month June Day 18 Year 1969		2b HOUR 10P M
3 SEX Male	4 RACE White	5 DATE OF BIRTH 11-20-76		6 AGE (In years last birthday) 92 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Italy	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince George's Md.		
10 CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George's Gen. Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) tile setter		12b KIND OF BUSINESS OR INDUSTRY Building
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD	13b COUNTY Prince George's	13c CITY OR TOWN Hyattsville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 5018 36th Place	
14. FATHER'S NAME First Middle Last unknown Barbagallo		15 MOTHER'S MAIDEN NAME First Middle Last Angelina unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) No		16b SOCIAL SECURITY NO 577/14/0214A		17 INFORMANT Thomas Barbagallo Address 13 a, b, c, d, e above	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PLEURAL EFFUSION DUE TO OR AS A CONSEQUENCE OF (c) CARCINOMA LUNG					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HRS 3 MOS 6 MOS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GREAT AGE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (u) (this hospital) attended the deceased from 1969 , to JUNE , 19 69 , that (u) (we) last saw the deceased alive on JUNE 18 , 19 69 , and that in (u) (my) (our) opinion death occurred on the date and hour and from the causes stated above (u) (we) (did) (d not) view the body after death.					
22b SIGNATURE Benjamin S. Miller MD				22c. DATE SIGNED 19 June 69	
22d PHYSICIAN'S NAME (Type) Benjamin S. Miller, M.D.		22e ADDRESS			
23a BURIAL CREMATION (Type) Burial	23b DATE 23 June '69	23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d LOCATION (City or Town) (County) (State) Washington, D.C.	
24 FUNERAL DIRECTOR Rinaldi Funeral Home, Inc		25a REC'D BY REGISTRAR JUN 23 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach the certificate papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical examiner notified and approved - Dr. John Kehon

08745		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08739	
1 DECEASED-NAME (Type or print)		First Marion		Middle T.		Last Barker	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1/19/ 17		2a. DATE OF DEATH Month 6 Day 29 Year 69	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Zoo Keeper		12b. KIND OF BUSINESS OR INDUSTRY U. S. G.	
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyatt.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First John Middle Barker Last Ethel		15. MOTHER'S MAIDEN NAME First Wise Middle Wise Last Wise					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO. W W 11 579 16 4908		17. INFORMANT Address Bertha Barker Wife Same as # L3			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 5 yr? Approximate interval between onset and death 5 yr?							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7-3, 1967 to 6-29, 1967 , that (I) (we) last saw the deceased alive on 6-20, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE George Hageage				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7-1-69	
22d. PHYSICIAN'S NAME (Type) George Hageage				22e. ADDRESS Cottage City, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 3, 1969		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.				25a. REGISTRY REGISTRAR DATE JUL 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

7769

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be filed in the office of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Angel			Barranco			June 2 nd 1969		8:15 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		F UNDER 1 YEAR MONTHS DAYS		
Male		White		06-01-69		— YRS		1		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MD		U.S.A.				Prince George's Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.			none				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			Prince George's Adelphi				YES <input type="checkbox"/> NO <input type="checkbox"/>		2206 Saranac St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Orlando O. Barranco			Trinidad Pequero							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
no			none		Orlando O. Barranco Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Atelectasis</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain damage due to chorio</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>PREMATURITY</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or RFD No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1969</u> , to <u>June 2, 1969</u> , that (I) (we) lost saw the deceased alive on <u>June 2, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Francisco Venegas MD</u>						22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <u>FRANCISCO VENEZAS</u>						22e. ADDRESS <u>3301 Sage Lane Bowie, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/4/69		Mt. Olivet		Washington D.C.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons Hyattsville, Md.						JUN 5 1969		<u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08747

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08741

1 DECEASED NAME (Type or print) First Middle Last <i>Daniel M. Barron</i>			2a. DATE OF DEATH 6 Month 20 Day 69 Year		2b. HOUR 2:10p M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7-10-03		6. AGE (In years last birthday) 65 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George Md.		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Landover	13d. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8610 Landover Rd.,
14. FATHER'S NAME First Middle Last William H. Barron		15. MOTHER'S MAIDEN NAME First Middle Last Annie M. Bell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO 577 09 7210		17. INFORMANT Helen. Kuklish (friend) and Medical Records	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Bilateral Broncho-pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Emphysema, Pulmonary</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Fatty infiltration of liver and cerebral atrophy</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>5 June, 1969</i> , to <i>20 June, 1969</i> , that (I) (we) last saw the deceased alive on <i>20 June, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>did</i> (did not) view the body after death.					
22b. SIGNATURE <i>Thomas M. Hutchins M.D.</i>		22c. DATE SIGNED <i>20 June 1969</i>		22d. PHYSICIAN'S NAME (Type) Thomas Hutchins, M.D.	
22e. ADDRESS 7315 Landover Rd., Hyattsville, Md.		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 23, 1969		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	
23d. LOCATION (City or Town) Colmar Manor Pro Geo		23e. COUNTY Md.		23f. STATE	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR JUN 25 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08742

1. DECEASED-NAME (Type or Print) MINNIE PETRELLO BASS			2a. DATE KNOWN OF DEATH MAY 21 1969			2b. HOUR 12:00 M		
3. SEX F	4. RACE W	5. DATE OF BIRTH MAR 17 1913	6. AGE (in years last birthday) 56	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD JUNE 21 1969		
7a. BIRTHPLACE (State or foreign country) Washington		7b. CIT. ZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges		
10. CITY OR TOWN OF DEATH Chesley		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NW		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b. COUNTY Pr Geo		13c. CITY OR TOWN Chesley		13d. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>		13e. STREET AND NUMBER 6117 Flanders Rd
14. FATHER'S NAME Anthony Petrello			15. MOTHER'S MAIDEN NAME Stella Bronca					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 579-01-7187		17. INFORMANT James Baro Chesley				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 571.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) Low minutes								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerosis Liver								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dayton Watkins		EXAMINER'S NAME (Type) DAYTON WATKINS		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 6-22-69		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JUNE 25, 1969		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		23d. LOCATION (City or Town) (County) (State) COHASSET MANOR PRINCE GEORGES MD.		
24. FUNERAL DIRECTOR W.W. Chambers' Co.		ADDRESS RIVERDALE MARYLAND		25a. REC'D BY REGISTRAR JUN 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

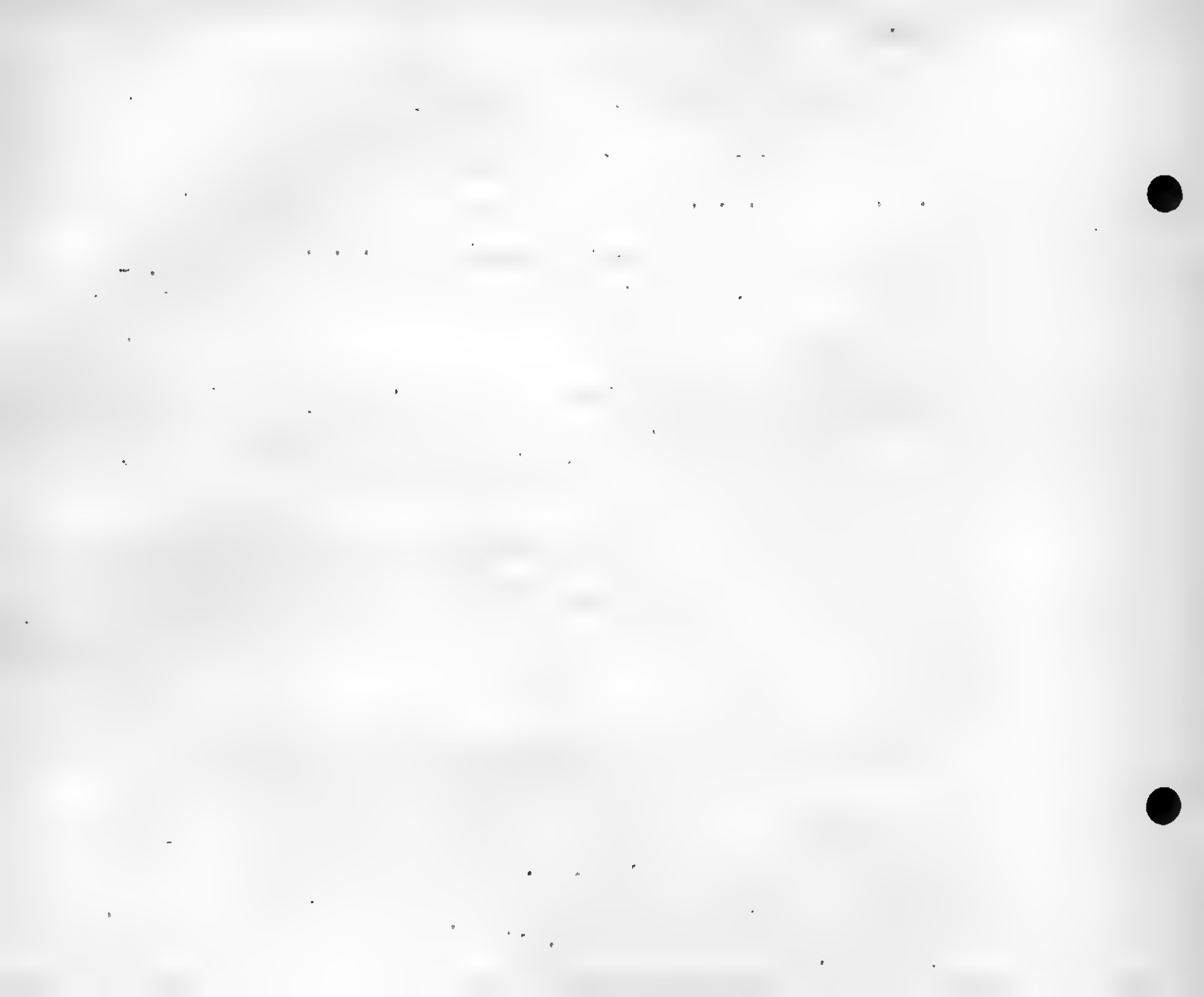
08749

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08743

1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Charles Wesley Baumberger						Month Day Year			2b. HOUR		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (in years last birthday)		
Male			White			3-2-1915			54 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
W.Va.			U.S.A.						Prince George's Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			D.D.S.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)			13b. COUNTY			13c. CITY OR TOWN			3d. INSIDE CITY LIMITS?		
Maryland			Prince George's			Bowie			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO		
Wesley Baumberger			Virginia Chaddock			Yes <input type="checkbox"/> No <input type="checkbox"/>			219-54-6972		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Marie V. Baumberger - above address			(Wife)			PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure			over 8 yrs		
						DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease					
						DUE TO, OR AS A CONSEQUENCE OF					
						(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			6-28-69					
John Kehoe MD			DEPUTY MEDICAL EXAMINER								
Riverdale, Md.			ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			7/1/69			Ft. Lincoln Cem.			Colmar Manor, Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Nalley's Funeral Home Inc.			JUL 3 1969			Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undertaker, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4409

1

08750

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08744

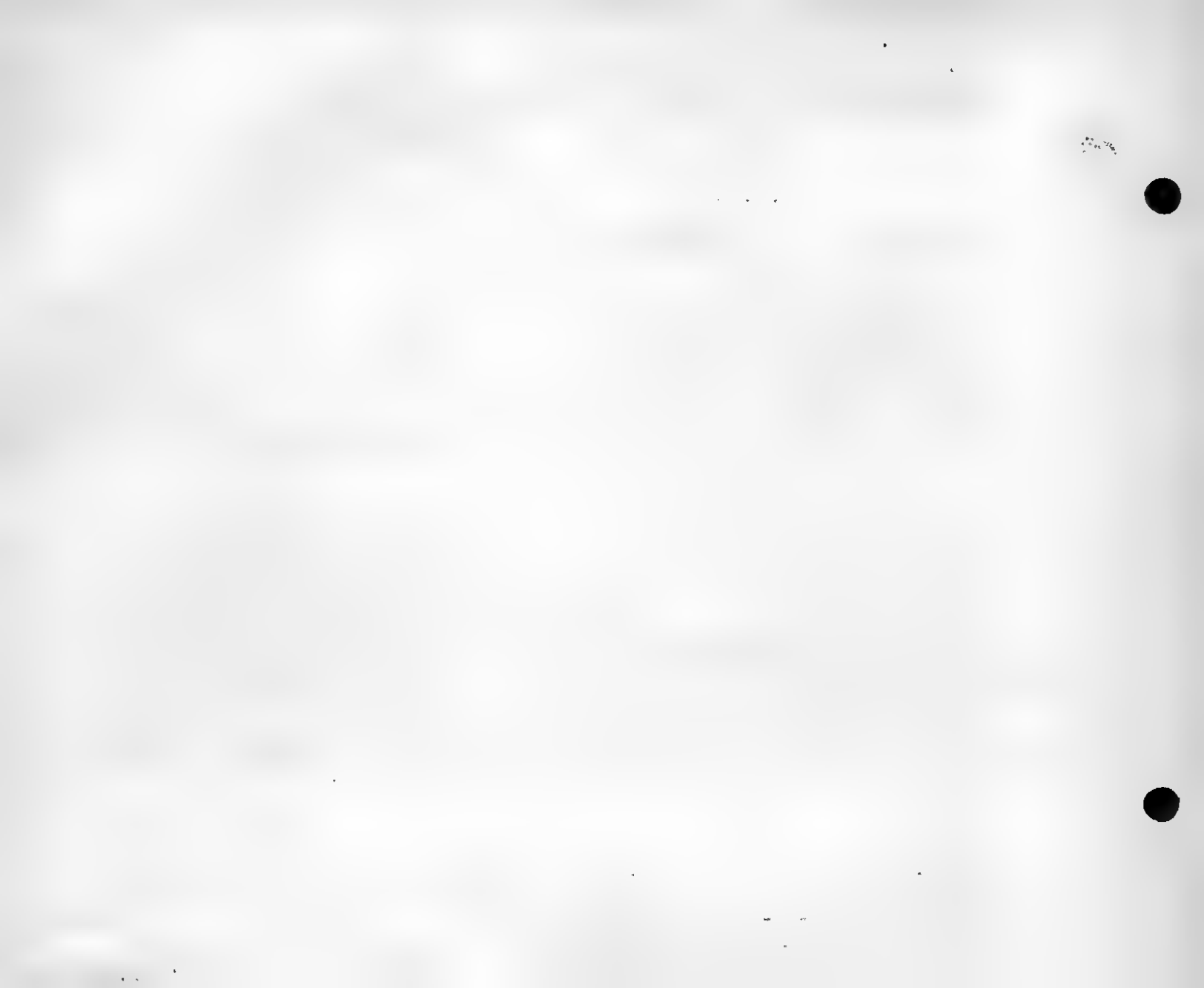
1. DECEASED-NAME (Type or print) Carrie		First A. Middle Baxter Last		2a. DATE OF DEATH Month June Day 5 Year 1969		2b. HOUR 9:35 AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH Aug. 3, 1877		6 AGE (In years lost birthday) 91 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH Hyattsville		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home Carroll Manor Nursing		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN University Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Philip		First Nally Middle Last		15. MOTHER'S MAIDEN NAME Ruth Ann Bell		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. none		17 INFORMANT Dorothy Aldridge Same as #13			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART 1. DEATH CAUSED BY. IMMEDIATE CAUSE (a) Cardiac and respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Shock DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4409 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 24° years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from 6/120 , 19 69 , to 6/5 , 19 69 , that (I) (we) lost saw the deceased alive on 6/4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David M. Goldman MD DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/5/69	
22d. PHYSICIAN'S NAME (Type) David M. Goldman, M.D.				22e. ADDRESS 3700 East-West Highway, Hyatts,			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/7/69		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery White Marsh P.G. Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR JUN 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Print or type)		First	Middle	Last	2a DATE OF DEATH	2b HOUR
08751 CHARLES ROBERT BECKER II					JUN Month 24 Day 69 Year	6:15 M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years)	7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male	Caucasian	12/19/1967	7 1/2 YRS.	PA	U.S.A.	9 COUNTY OF DEATH PRINCE GEORGE Md
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY			
ANDREWS AFB	MALCOLM GROW USAFHOSP	NA	N A			
13a USUAL RESIDENCE (Where deceased lived, if at institution, residence before admission) STATE	13b CITY OR TOWN	13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d STREET AND NUMBER			
MD	PRINCE GEORGE	INDIANHEAD	Apt 3-L Scan Land Rd			
14. FATHER'S NAME	15 MOTHER'S MAIDEN NAME					
First Middle Last	First Middle Last					
DAVID CHARLES BECKER	LINDA ANN CALLOWAY					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO	17 INFORMANT	Address			
NO	NO	FATHER SAME AS ITEM #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART 1 DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) ACUTE SUPPURATIVE PURULENT MENINGITIS						
DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
(b) DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that (X) (this hospital) attended the deceased from 24 Jun, 19 69, to 24 Jun, 19 69, that (X) (we) last saw the deceased alive on 24 Jun, 19 69, and that in (MD) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.						
22b SIGNATURE	22c DATE SIGNED					
G. DUBOIS, MD	24 Jun 69					
22d. PHYSICIAN'S NAME (Type)	22e ADDRESS					
G. DUBOIS, CAPT, USAF, MC	MALCOLM GROW USAFHOSP ANDREWS AFB					
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)	
Burial	6-28-69	Jefferson Memorial	Pittsburgh	Pennsylvania		
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert E. Wilhelm Funeral Home			DATE JUN 30 1969		Charles Judge	
4308 Suitland Road Suitland Maryland						

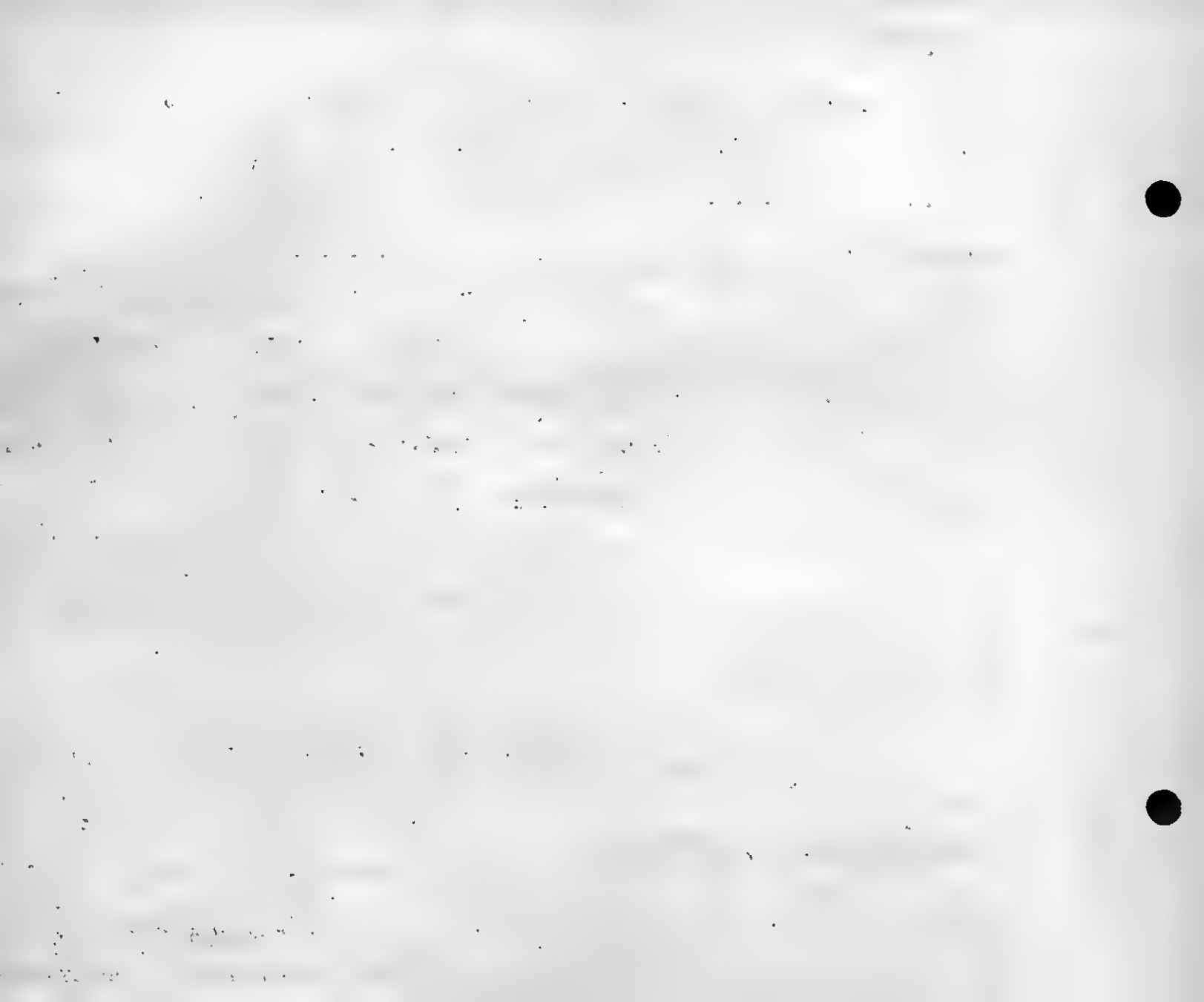


0381

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08752		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08746	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR P M
LEONARD		CURTIS	BELL		JUN Month 18 Day 69 Year		3:28 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
MALE		NEGROID		30 Nov 1935		33 YRS	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
PA.		U.S.A.				PRINCE GEORGE Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
ANDREWS AFB		MALCOLM GROW USAFHOSP		U.S.A.F.			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MASS		13b COUNTY		WESTOVER AFB		13e. STREET AND NUMBER	
						19 Bennett St	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
ALFRED		BELL	JR		VIRGINIA DARE		WILKINS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address	
YES		207-26-9251		WIFE SAME AS ITEM #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>							2 hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Staphylococcal septicemia</u>							14 days
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		No	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		City or Town County State	
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.			
22a. I certify that (X) (this hospital) attended the deceased from <u>13 Jun</u> , 19 <u>69</u> , to <u>18 Jun</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>18 Jun</u> , 19 <u>69</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED	
<u>W. W. Chamberlain, M.D.</u>						18 Jun 69	
22d. PHYSICIAN'S NAME (Type)		DUNCAN CAPT USAF MG		22e. ADDRESS		MALCOLM GROW USAFHOSP ANDREWS AFB	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		6-23-69		Fairview Cem.		Phila. Penna.	
24 FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>W. W. Chamberlain</u>		517-113		DATE JUN 23 1969		<u>W. W. Chamberlain</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Gladys			Berlin			Month 6 Day 4 Year 69			1705 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female		cauc		Dec. 1892		76 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Russia		U.S.A.				PRINCE GEORGES'			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
andrews air force base		MALCOLM GROW USAF HOSP		retired		INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Mass.					Chicopee		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		183 Jacobs St.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Morris Horowitz			Ida Horowitz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT				
no			133-16-7684		Florence (daughter) Chimelis (same as #13a,c,&e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Surgery</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Intestinal obstruction and abdominal abscess</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
4 June 69		Abd. abscess		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		21g. CITY OR TOWN			
				Street or R.F.D. No		City or Town			
						County			
						State			
22a. I certify that (I) (this hospital) attended the deceased from <u>14 May</u> , 19 <u>69</u> , to <u>4 June</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4 June 69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death									
22b. SIGNATURE		22c. DATE SIGNED							
<u>John M. Clarke, MD</u>		<u>4 June 69</u>							
22d. PHYSICIAN'S		22e. ADDRESS							
JOHN M. CLARKE MAJ USAF MSC		MALCOLM GROW USAF HOSP ANDREWS AFB MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. COUNTY (State)	
Burial		6-6-1969		Beth Israel Cemetery		West Springfield		Mass.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. DATE			
Goldberg Funeral Home 4217 9th St., N.W.				JUN 9 1969					

MEDICAL CERTIFICATION

5684

1

08753

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08747



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08754

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08748

1. DECEASED NAME (Type or Print) ROBERT E BERRY			2a. DATE KNOWN OF EST DEATH MATED <input type="checkbox"/> Month Day Year June 21, 1969			2b. HOUR M		
3. SEX M	4. RACE W	5. DATE OF BIRTH Oct 7, 1907	6. AGE (In years last birthday) 61 YRS	7. IF UNDER 1 YEAR MONTHS DAYS 	8. IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD Month Day Year June 21 1969		
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Pro Georges Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Pharmacist		12b. KIND OF BUSINESS OR INDUSTRY Drug Store		
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Md		13b. COUNTY Pro Geo		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6905 96th avenue,.
14. FATHER'S NAME First Middle Last Esther A Palmer				15. MOTHER'S MAIDEN NAME First Middle Last Esther A Palmer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 172 03 3275		17. INFORMANT ADDRESS Mary A Berry Seabrook, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a) stating the underlying cause lost } (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Heart Block								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dayton Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6-21-69		
EXAMINER'S NAME (Type) DAYTON WATKINS		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 24, 1969		23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery		23d. LOCATION (City or Town) (County) (State) Johnstown Cambria Pa		
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR JUN 25 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

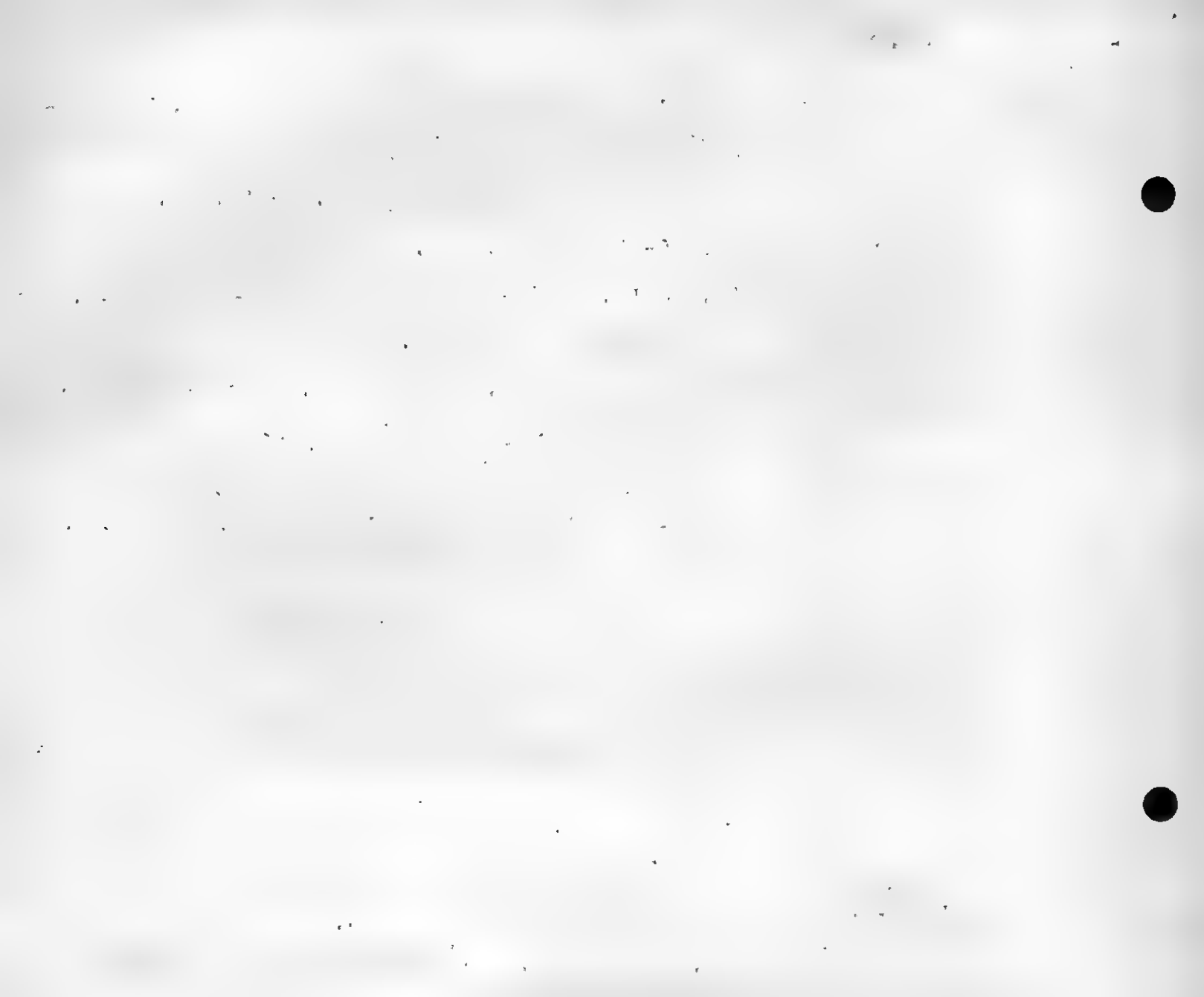


4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08755		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08749	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
Samuel S. Berry				June 8th, 1969		3-A. M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 1 YEAR MONTHS	8. UNDER 24 HRS. HOURS	9. UNDER 24 HRS. MIN.
Male	White	July 4th, 1883		85 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Penn		USA		Pr. Geo's. Co.		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Silesia		11400- Fort Wash., Rd.		Retired		Carpenter	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Maryland		Pr. Geo's.	Silesia	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	11400- Fort Wash., Rd		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service)			
Robert Berry		Mary E. Rowe		Yes Peace Time			
16a. SOCIAL SECURITY NO.		17. INFORMANT		Address Same as Mrs. Charlotte E. Floyd Number 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100		CORONARY THROMBOSIS		8 HRS			
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIAC DISEASE		XRS					
DUE TO, OR AS A CONSEQUENCE OF (c) GENERAL ARTERIOSCLEROSIS		XRS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MAR 13, 1961, to JUN 8, 1969, that (I) (we) last saw the deceased alive on JUN 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
Paul Chen, M.D.		JUN 8, 1969		PAUL CHEN, M.D.			
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS			
Accokeek, Md. 20607		Accokeek, Md. 20607		Accokeek, Md. 20607			
23a. BURIAL CREMATION <input checked="" type="checkbox"/> REMOVAL <input type="checkbox"/> (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		June 10-69		Arlington National Cem. Arlington, Virginia			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Simmons Bros.		JUN 10 1969		Charles Judge			
Simmons Bros-1661-Gd.Hope Rd. SE. DC.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08756										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08750									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Barbara Jean Blimmel										Month June Day 13 Year 1969										10:45 AM									
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS														
Female			White			10-17-35			33 YRS.			MONTHS			DAYS			HOURS			MIN								
7a. BIRTH-PLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Pennsylvania			U.S.A.						Prince George's																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY																				
Cheverly			Prince George's Gen. Hosp.			Registered Nurse			Hospitals																				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
ENGLAND						Cheltenham			YES <input type="checkbox"/> NO <input type="checkbox"/>			46 Christ Church Road																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
Robert B. Irwin			Mildred J. Hommel																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOC. A. SECURITY NO			17. INFORMANT			Address																				
no			165 28 0729			James Q Blimmel			Same as #13																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Increased intra-cranial pressure with																													
DUE TO, OR AS A CONSEQUENCE OF herniation of brain stem																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) Tumor of left temporal lobe																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 6/6, 1969, to 6/13, 1969, that (I) (we) last saw the deceased alive on 6/13, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
Norman D. Comeau, M.D.										6/13/69																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
										3503 Perry Street Mt. Rainier, MD																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					6/16/69					Ft. Lincoln					Colmar Manor P.G. Md.														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
F. Lasch's Sons Hyattsville, Md.										JUN 18 1969										Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

08757

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08751

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
MYRTLE L. BOWEN						JUNE 27 1969			50		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
F		W		2-24-17		52 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. Va.		USA				Pr. Geo's.		Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CLINTON		CLINTON COMMUNITY HOSP.				HOUSEWIFE		DOMESTIC			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		Pr. Georges		CLINTON				8102-Md Avenue			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Unknown			Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
						BENJAMIN H. BOWEN		Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 10 min.											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> 10-15 min.											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Coronary Artery Disease with</u> 5+ years											
PART 2. OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE SHOWN IN PART 1.)											
<u>None</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
<u>None</u>		<u>None</u>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, month, med cert examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
<input type="checkbox"/>		HOUR A.M. Month Day Year		<u>None</u>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
<u>None</u>		<u>None</u>		<u>None</u>							
22a. I certify that (I) (was hospital) attended the deceased from <u>June 3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
<u>Arthur Shaver Jr MD</u>		<u>June 27, 1969</u>									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
<u>ARTHUR SHAVER JR MD</u>		<u>8808 BRANCH AVE CLINTON, MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
<u>Burial</u>		<u>June 30-69</u>		<u>Cedar Hill Cemetery</u>		<u>Switzland, Md.</u>					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>Simmons Bros</u>		<u>Wash DC</u>		<u>JUL 1 1969</u>		<u>Charles Judge</u>					

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
08755 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR	
FRANCES IDA BOYD						June 20 1969		— M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD		2d. HOUR
F	W	2-28-26	43 YRS				June 20 1969		8:05 A M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Virginia		USA				Prince Georges		Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Georges Gen			Accountant		Business	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER	
Md			Pr Geo Riverdale			YES		5408 Newby St	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
GEORGE H BOYD			ANNA MacINNIS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS	
no			None			Sister Alvin Jones		5408 Newby St Riverdale Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Rt occipital DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
									1 day
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			6-21-69			
DAYTON O WATKINS			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			6/24/69			Arlington Natl. Cem.			Fort Myer Virginia
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. Wm. Lees Sons, Co., Washington, D.						DATE JUN 26 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

08753 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 8 Film 413 6/10/69 kk		CERTIFICATE OF DEATH		08753						
1 DECEASED-NAME (Type or print)			First Middle Last		2a DATE OF DEATH		2b HOUR			
<i>Mary Boyle</i>					<i>JUNE Month 4 Day 1969 Year 9³⁰A.M.</i>					
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (n years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
<i>F</i>		<i>White</i>		<i>Feb. 18, 1891</i>		<i>76 YRS.</i>				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
<i>Pa.</i>		<i>U.S.A.</i>				<i>Prince Georges Md.</i>				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				
<i>Lanham</i>			<i>magnolia Gardens Nursing Home Lanham</i>			<i>Ex. voice Co</i>				
13a USUAL RESIDENCE (Where deceased lived, if institution) STATE			13b COUNTY			13c CITY OR TOWN				
<i>md</i>			<i>Frederick</i>			<i>Riverdale</i>				
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
<i>edgar Boland</i>			<i>Catherine</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Address				
<i>no</i>			<i>None</i>			<i>Grace Proud E. Street</i>				
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Shrunken of left femoral artery</i>								<i>1 day</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerosis heart & coronary c</i>								<i>yes</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>atrophy of brain</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>hypertension & hypercholesterolemia & cerebral arteriosclerosis</i>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. P.M. Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)						
<input type="checkbox"/> Not while at work <input type="checkbox"/> While at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State						
22a I certify that (I) (the hospital) attended the deceased from <i>June 1st, 1966</i> , to <i>June 4th, 1969</i> , that (I) (we) lost saw the deceased alive on <i>June 4th, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>H. Bergeman</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <i>6/4/69</i>			
22d PHYSICIAN'S NAME (Type) <i>HILL BERGEMAN, M.D.</i>					22e ADDRESS					
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
<i>BURIAL</i>		<i>6/6/69</i>		<i>St Mary's Cemetery</i>		<i>Wilkes Barre Luzerne Pa</i>				
24 FUNERAL DIRECTOR <i>F. Lascik's sons</i>					ADDRESS <i>Hwy 61 Rt 160</i>		25a REC'D BY REGISTRAR DATE JUN 6 1969		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08754							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08760							
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH MATED			Month Day Year		2b HOUR			
Harry			Edgar		Brandt					6-22-69		19		M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR			
Male		White		11/19/18		50 YRS						6 22 69		19 6:34 pm			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH								
Md			U S A						Prince George's			Md					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY					
Cheverly				Prince George Hospital													
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland				Prince George's				Edmonston						5303 Decatur Street			
14 FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last												
Harry C Brandt					Lillian Mahorney												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes <input checked="" type="checkbox"/> no <input type="checkbox"/> (If yes give war or dates of service) W W 11					16b. SOCIAL SECURITY NO 578 01 6157					17. INFORMANT ADDRESS Harry E Brandt Jr Lexington, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of chest																	
355X DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c) DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 6-22-19 69					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot self at home							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home					21f LOCATION Street or RFD No City or Town County State same as #13							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					22b. DATE SIGNED 6-24-69							
ADDRESS (Street, city, town, or county) Riverdale, Md.																	
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)							
Burial				June 27, 1969		Baltimore National				Baltimore, Md							
24 FUNERAL DIRECTOR F. Gasch's Sons						ADDRESS Hyattsville, Md.				25a REC'D BY REGISTRAR JUN 27 1969		25b REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

08761		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08755	
Item 6 film 413 6/23/69 kk							
1 DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First Middle Last Elizabeth Katherine BRAZERO				Month Day Year JUNE 12 1969		M	
3 SEX Female		4 RACE W		5 DATE OF BIRTH Sept. 1-1881		6 AGE (In years last birthday) 88 YRS.	
7a. BIRTHPLACE (State or foreign country) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md	
10. CITY OR TOWN OF DEATH Hyattsville Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HYATTSVILLE NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during usual working life, even if retired) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. TREASURY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.		13b. COUNTY W		13c. CITY OR TOWN WASHINGTON		13d. INS. DE. CITY, AUTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 909 QUINCY ST. N.E.		14. FATHER'S NAME First Middle Last LEWIS M. BYRNES		15. MOTHER'S MAIDEN NAME First Middle Last ANNIE CORCORAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown No	
16b. SOCIAL SECURITY NO 579-52-3415		17. INFORMANT KATHRYN F. O'CONNELL		Address 2024 HAYDEN RD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD C congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1965 to 6/12, 1969, that (I) (we) lost saw the deceased alive on 6/12, 1969; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R.B. IREY				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) R.B. IREY				22e. ADDRESS 11161 N. H. Ave. Silver Spring, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-16-69		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR James J. Collins				ADDRESS 500 University Blvd W Silver Spring, Md		25a. REC'D BY REGISTRAR DATE JUN 17 1969	
				25b. REGISTRAR'S SIGNATURE G. L. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08762		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08756	
Item 8 Film 44 7/1/69 kk					
1 DECEASED NAME (Type or print)		First <u>A.K.A. Elizabeth</u> Middle <u>Bessie</u> Last <u>Breece</u>		2a. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1969</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		2b. HOUR <u>3:20A</u>	
5 DATE OF BIRTH <u>Jan. 26, 1896</u>		6. AGE (In years last birthday) <u>73</u> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>New York</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <u>Cheverly</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince George's Gen. Hosp.</u>		9. COUNTY OF DEATH <u>Prince George's</u> Md	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Prince George's</u>		13c. CITY OR TOWN <u>Cheverly</u>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>6008 Inwood</u>		<u>st</u>	
14 FATHER'S NAME First <u>Paul</u> Middle <u>Boyd</u> Last		15. MOTHER'S MAIDEN NAME First <u>Gertrude</u> Middle <u>Wittman</u> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <u>no</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>097 01 4576</u>		17 INFORMANT Address <u>Dolores B Schmidt Cheverly, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the doctor) attended the deceased from <u>5-16-69</u> , 19 <u>69</u> , to <u>June 21</u> , 1969, that (I) was last saw the deceased alive on <u>June 21, 1969</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death.					
22b. SIGNATURE <u>Roger B. Ingham</u>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>6-22-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Ingham Roger M.D.</u>		22e. ADDRESS <u>5701 85th Avenue Washington D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 24, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Flushing Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Flushing Long Island N Y</u>					
24 FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 25 1969</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM-3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08763

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR			
Larry		D		Brooks				6-23-69		19		50		am		M			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year			
Male	Negro	3-6-1955		14 YRS		MONTHS		DAYS		6		23		69		19 9:50am M			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH								Md			
12a. Md.		U.S.A.		WIDOWED		DIVORCED		Prince George's											
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY							
Cheverly				Prince George Hospital															
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d ASIDE CITY LIMITS?				13e STREET AND NUMBER			
Maryland				Prince George's				Brandywine				YES <input type="checkbox"/> NO <input type="checkbox"/>				Box 10 Old Indianhead Rd. Rt3,			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME															
Chester Brooks				Mildred Mitchell															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17 INFORMANT				ADDRESS							
								Chester Brooks - same as above											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain																			
161 DUE TO, OR AS A CONSEQUENCE OF Trauma - auto accident																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
MEDICAL CERTIFICATION																			
19a DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year						21c HOW INJURY OCCURRED (Enter nature and circumstances)							
						6:39pm 6-20- 19 69						Passenger in car which went out of control							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or RFD No							
						Rt. 381 & Shortcut Rd.,						City or Town							
						Brandywine, Prince George County, Maryland						County							
												State							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER						22b DATE SIGNED							
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER						6-23-69							
John Kehoe MD						DEPUTY MEDICAL EXAMINER													
Riverdale, Md.						ADDRESS (Street, city, town, or county)													
23a BURIAL CREMATION REMOVAL (Specify)						23b DATE						23c NAME OF CEMETERY OR CREMATORY							
Burial						6-27-69						Union Bethel Ch. Cem. Brandywine, P. Geo. Md.							
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR						25b REGISTRAR'S SIGNATURE							
Martell Adams Aquasco, Md.						DATE JUL 2 1969						Richard Judge							

4122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First		Middle		Last		2e. DATE OF DEATH		
Charles			Middle		Brown				Month Day Year June 9, 1969		
3 SEX			4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7b HOUR	
Male			White		07-27-04			64 YRS		8:30A M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Maryland			U.S.A.						Prince George's Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp								
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13e STREET AND NUMBER		
MD			Prince George's			Hyattsville			3713 Jefferson Street		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME		
William			Brown						Josephine		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
			139-05-3719			Mrs. Mildred M. Brown			3713 Jefferson St. Hyattsville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive (Cardio-Vascular) Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 yr.</u> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>69</u> , to <u>6/9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE			22c DATE SIGNED			22d PHYSICIAN'S NAME (Type)			22e ADDRESS		
<u>William H. Carter</u>			<u>6/9/69</u>			<u>W. H. Carter</u>			<u>3503 Pennsylvania Avenue Md.</u>		
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		25a REC'D BY REGISTRAR	
			<u>June 10, 1969</u>		<u>St. John's Cemetery</u>			<u>Hyattsville, Prince George's</u>		<u>JUN 16 1969</u>	
25a REGISTRAR'S SIGNATURE			25b REGISTRAR'S SIGNATURE			25c REGISTRAR'S SIGNATURE			25d REGISTRAR'S SIGNATURE		
<u>William H. Carter</u>			<u>William H. Carter</u>			<u>William H. Carter</u>			<u>William H. Carter</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08765

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08759

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR		
Norman			L.		Brown	June 25 1969			1:15 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		8/3/1898		70 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Wash., D.C.		U.S.A.				Prince George's Md.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a U.S.A. OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp.				Ret.-Sales Mgr.		Bakery			
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
MD		Prince George's		Landover				Box 1214			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
William					Brown	Emily					Norris
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address					
No				577-05-5857		Maude N. Brown (above address) (wife)					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral lobar pneumonia											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) Bilateral pneumo-thrombo emboli with infarction of lungs											
DUE TO OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21a INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f LOCATION		Street or RFD No		City or Town		County	State
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a I certify that (I) (this hospital) attended the deceased from June 1969, to June 25 1969, that (I) (we) last saw the deceased alive on June 25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED		
Don B. Cameron									June 26, 1969		
22d PHYSICIAN'S NAME (Type)					22e ADDRESS						
Don B. Cameron, M.D.					3503 Perry St.		Mt. Rainier, MD				
23a BURIAL CREMATION, (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		6/30/69		Ft. Lincoln Cem.		Colmar Manor, Md.					
24. FUNERAL DIRECTOR					ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Nalley's Funeral Home Inc.					Mt. Rainier, Maryland		JUL 2 1969		Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08760		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08760	
1. DECEASED NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
MARY				6 Month 30 Day 69 Year		6 45 AM	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	
FEM.		WHITE		JAN. 27, 1885		84 YRS.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
NEW YORK		U.S.A.		PR. GEO.		Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
HYATTSVILLE		4922 LASALLE RD		None			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, LHM TSP	
13e. STREET AND NUMBER		13f. COUNTY		13g. CITY OR TOWN		13h. INSIDE CITY, LHM TSP	
13i. STREET AND NUMBER		13j. COUNTY		13k. CITY OR TOWN		13l. INSIDE CITY, LHM TSP	
13m. STREET AND NUMBER		13n. COUNTY		13o. CITY OR TOWN		13p. INSIDE CITY, LHM TSP	
13q. STREET AND NUMBER		13r. COUNTY		13s. CITY OR TOWN		13t. INSIDE CITY, LHM TSP	
13u. STREET AND NUMBER		13v. COUNTY		13w. CITY OR TOWN		13x. INSIDE CITY, LHM TSP	
13y. STREET AND NUMBER		13z. COUNTY		13aa. CITY OR TOWN		13ab. INSIDE CITY, LHM TSP	
13ac. STREET AND NUMBER		13ad. COUNTY		13ae. CITY OR TOWN		13af. INSIDE CITY, LHM TSP	
13ag. STREET AND NUMBER		13ah. COUNTY		13ai. CITY OR TOWN		13aj. INSIDE CITY, LHM TSP	
13ak. STREET AND NUMBER		13al. COUNTY		13am. CITY OR TOWN		13an. INSIDE CITY, LHM TSP	
13ao. STREET AND NUMBER		13ap. COUNTY		13aq. CITY OR TOWN		13ar. INSIDE CITY, LHM TSP	
13as. STREET AND NUMBER		13at. COUNTY		13au. CITY OR TOWN		13av. INSIDE CITY, LHM TSP	
13aw. STREET AND NUMBER		13ax. COUNTY		13ay. CITY OR TOWN		13az. INSIDE CITY, LHM TSP	
13ba. STREET AND NUMBER		13bb. COUNTY		13bc. CITY OR TOWN		13bd. INSIDE CITY, LHM TSP	
13be. STREET AND NUMBER		13bf. COUNTY		13bg. CITY OR TOWN		13bh. INSIDE CITY, LHM TSP	
13bi. STREET AND NUMBER		13bj. COUNTY		13bk. CITY OR TOWN		13bl. INSIDE CITY, LHM TSP	
13bm. STREET AND NUMBER		13bn. COUNTY		13bo. CITY OR TOWN		13bp. INSIDE CITY, LHM TSP	
13bq. STREET AND NUMBER		13br. COUNTY		13bs. CITY OR TOWN		13bt. INSIDE CITY, LHM TSP	
13bu. STREET AND NUMBER		13bv. COUNTY		13bw. CITY OR TOWN		13bx. INSIDE CITY, LHM TSP	
13by. STREET AND NUMBER		13bz. COUNTY		13ca. CITY OR TOWN		13cb. INSIDE CITY, LHM TSP	
13cc. STREET AND NUMBER		13cd. COUNTY		13ce. CITY OR TOWN		13cf. INSIDE CITY, LHM TSP	
13cg. STREET AND NUMBER		13ch. COUNTY		13ci. CITY OR TOWN		13cj. INSIDE CITY, LHM TSP	
13ck. STREET AND NUMBER		13cl. COUNTY		13cm. CITY OR TOWN		13cn. INSIDE CITY, LHM TSP	
13co. STREET AND NUMBER		13cp. COUNTY		13cq. CITY OR TOWN		13cr. INSIDE CITY, LHM TSP	
13cs. STREET AND NUMBER		13ct. COUNTY		13cu. CITY OR TOWN		13cv. INSIDE CITY, LHM TSP	
13cw. STREET AND NUMBER		13cx. COUNTY		13cy. CITY OR TOWN		13cz. INSIDE CITY, LHM TSP	
13da. STREET AND NUMBER		13db. COUNTY		13dc. CITY OR TOWN		13dd. INSIDE CITY, LHM TSP	
13de. STREET AND NUMBER		13df. COUNTY		13dg. CITY OR TOWN		13dh. INSIDE CITY, LHM TSP	
13di. STREET AND NUMBER		13dj. COUNTY		13dk. CITY OR TOWN		13dl. INSIDE CITY, LHM TSP	
13dm. STREET AND NUMBER		13dn. COUNTY		13do. CITY OR TOWN		13dp. INSIDE CITY, LHM TSP	
13dq. STREET AND NUMBER		13dr. COUNTY		13ds. CITY OR TOWN		13dt. INSIDE CITY, LHM TSP	
13du. STREET AND NUMBER		13dv. COUNTY		13du. CITY OR TOWN		13dv. INSIDE CITY, LHM TSP	
13dw. STREET AND NUMBER		13dx. COUNTY		13dw. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13dy. STREET AND NUMBER		13dx. COUNTY		13dy. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13dz. STREET AND NUMBER		13dx. COUNTY		13dz. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ea. STREET AND NUMBER		13dx. COUNTY		13ea. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13eb. STREET AND NUMBER		13dx. COUNTY		13eb. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ec. STREET AND NUMBER		13dx. COUNTY		13ec. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ed. STREET AND NUMBER		13dx. COUNTY		13ed. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ee. STREET AND NUMBER		13dx. COUNTY		13ee. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ef. STREET AND NUMBER		13dx. COUNTY		13ef. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13eg. STREET AND NUMBER		13dx. COUNTY		13eg. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13eh. STREET AND NUMBER		13dx. COUNTY		13eh. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ei. STREET AND NUMBER		13dx. COUNTY		13ei. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ej. STREET AND NUMBER		13dx. COUNTY		13ej. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ek. STREET AND NUMBER		13dx. COUNTY		13ek. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13el. STREET AND NUMBER		13dx. COUNTY		13el. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13em. STREET AND NUMBER		13dx. COUNTY		13em. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13en. STREET AND NUMBER		13dx. COUNTY		13en. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13eo. STREET AND NUMBER		13dx. COUNTY		13eo. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ep. STREET AND NUMBER		13dx. COUNTY		13ep. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13eq. STREET AND NUMBER		13dx. COUNTY		13eq. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13er. STREET AND NUMBER		13dx. COUNTY		13er. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13es. STREET AND NUMBER		13dx. COUNTY		13es. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13et. STREET AND NUMBER		13dx. COUNTY		13et. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13eu. STREET AND NUMBER		13dx. COUNTY		13eu. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ev. STREET AND NUMBER		13dx. COUNTY		13ev. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ew. STREET AND NUMBER		13dx. COUNTY		13ew. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ex. STREET AND NUMBER		13dx. COUNTY		13ex. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ey. STREET AND NUMBER		13dx. COUNTY		13ey. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ez. STREET AND NUMBER		13dx. COUNTY		13ez. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fa. STREET AND NUMBER		13dx. COUNTY		13fa. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fb. STREET AND NUMBER		13dx. COUNTY		13fb. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fc. STREET AND NUMBER		13dx. COUNTY		13fc. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fd. STREET AND NUMBER		13dx. COUNTY		13fd. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fe. STREET AND NUMBER		13dx. COUNTY		13fe. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ff. STREET AND NUMBER		13dx. COUNTY		13ff. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fg. STREET AND NUMBER		13dx. COUNTY		13fg. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fh. STREET AND NUMBER		13dx. COUNTY		13fh. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fi. STREET AND NUMBER		13dx. COUNTY		13fi. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fj. STREET AND NUMBER		13dx. COUNTY		13fj. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fk. STREET AND NUMBER		13dx. COUNTY		13fk. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fl. STREET AND NUMBER		13dx. COUNTY		13fl. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fm. STREET AND NUMBER		13dx. COUNTY		13fm. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fn. STREET AND NUMBER		13dx. COUNTY		13fn. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fo. STREET AND NUMBER		13dx. COUNTY		13fo. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fp. STREET AND NUMBER		13dx. COUNTY		13fp. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fq. STREET AND NUMBER		13dx. COUNTY		13fq. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fr. STREET AND NUMBER		13dx. COUNTY		13fr. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fs. STREET AND NUMBER		13dx. COUNTY		13fs. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ft. STREET AND NUMBER		13dx. COUNTY		13ft. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fu. STREET AND NUMBER		13dx. COUNTY		13fu. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fv. STREET AND NUMBER		13dx. COUNTY		13fv. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fw. STREET AND NUMBER		13dx. COUNTY		13fw. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fx. STREET AND NUMBER		13dx. COUNTY		13fx. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fy. STREET AND NUMBER		13dx. COUNTY		13fy. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13fz. STREET AND NUMBER		13dx. COUNTY		13fz. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ga. STREET AND NUMBER		13dx. COUNTY		13ga. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gb. STREET AND NUMBER		13dx. COUNTY		13gb. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gc. STREET AND NUMBER		13dx. COUNTY		13gc. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gd. STREET AND NUMBER		13dx. COUNTY		13gd. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ge. STREET AND NUMBER		13dx. COUNTY		13ge. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gf. STREET AND NUMBER		13dx. COUNTY		13gf. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gg. STREET AND NUMBER		13dx. COUNTY		13gg. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gh. STREET AND NUMBER		13dx. COUNTY		13gh. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gi. STREET AND NUMBER		13dx. COUNTY		13gi. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gj. STREET AND NUMBER		13dx. COUNTY		13gj. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gk. STREET AND NUMBER		13dx. COUNTY		13gk. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gl. STREET AND NUMBER		13dx. COUNTY		13gl. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gm. STREET AND NUMBER		13dx. COUNTY		13gm. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gn. STREET AND NUMBER		13dx. COUNTY		13gn. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13go. STREET AND NUMBER		13dx. COUNTY		13go. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gp. STREET AND NUMBER		13dx. COUNTY		13gp. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gq. STREET AND NUMBER		13dx. COUNTY		13gq. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gr. STREET AND NUMBER		13dx. COUNTY		13gr. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gs. STREET AND NUMBER		13dx. COUNTY		13gs. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gt. STREET AND NUMBER		13dx. COUNTY		13gt. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gu. STREET AND NUMBER		13dx. COUNTY		13gu. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gv. STREET AND NUMBER		13dx. COUNTY		13gv. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gw. STREET AND NUMBER		13dx. COUNTY		13gw. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gx. STREET AND NUMBER		13dx. COUNTY		13gx. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gy. STREET AND NUMBER		13dx. COUNTY		13gy. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13gz. STREET AND NUMBER		13dx. COUNTY		13gz. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ha. STREET AND NUMBER		13dx. COUNTY		13ha. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hb. STREET AND NUMBER		13dx. COUNTY		13hb. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hc. STREET AND NUMBER		13dx. COUNTY		13hc. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hd. STREET AND NUMBER		13dx. COUNTY		13hd. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13he. STREET AND NUMBER		13dx. COUNTY		13he. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hf. STREET AND NUMBER		13dx. COUNTY		13hf. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hg. STREET AND NUMBER		13dx. COUNTY		13hg. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hh. STREET AND NUMBER		13dx. COUNTY		13hh. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hi. STREET AND NUMBER		13dx. COUNTY		13hi. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hj. STREET AND NUMBER		13dx. COUNTY		13hj. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hk. STREET AND NUMBER		13dx. COUNTY		13hk. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hl. STREET AND NUMBER		13dx. COUNTY		13hl. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hm. STREET AND NUMBER		13dx. COUNTY		13hm. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hn. STREET AND NUMBER		13dx. COUNTY		13hn. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ho. STREET AND NUMBER		13dx. COUNTY		13ho. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hp. STREET AND NUMBER		13dx. COUNTY		13hp. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hq. STREET AND NUMBER		13dx. COUNTY		13hq. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hr. STREET AND NUMBER		13dx. COUNTY		13hr. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hs. STREET AND NUMBER		13dx. COUNTY		13hs. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ht. STREET AND NUMBER		13dx. COUNTY		13ht. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hu. STREET AND NUMBER		13dx. COUNTY		13hu. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hv. STREET AND NUMBER		13dx. COUNTY		13hv. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hw. STREET AND NUMBER		13dx. COUNTY		13hw. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hx. STREET AND NUMBER		13dx. COUNTY		13hx. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hy. STREET AND NUMBER		13dx. COUNTY		13hy. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13hz. STREET AND NUMBER		13dx. COUNTY		13hz. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ia. STREET AND NUMBER		13dx. COUNTY		13ia. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ib. STREET AND NUMBER		13dx. COUNTY		13ib. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ic. STREET AND NUMBER		13dx. COUNTY		13ic. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13id. STREET AND NUMBER		13dx. COUNTY		13id. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ie. STREET AND NUMBER		13dx. COUNTY		13ie. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13if. STREET AND NUMBER		13dx. COUNTY		13if. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ig. STREET AND NUMBER		13dx. COUNTY		13ig. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ih. STREET AND NUMBER		13dx. COUNTY		13ih. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ii. STREET AND NUMBER		13dx. COUNTY		13ii. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ij. STREET AND NUMBER		13dx. COUNTY		13ij. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13ik. STREET AND NUMBER		13dx. COUNTY		13ik. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13il. STREET AND NUMBER		13dx. COUNTY		13il. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13im. STREET AND NUMBER		13dx. COUNTY		13im. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13in. STREET AND NUMBER		13dx. COUNTY		13in. CITY OR TOWN		13dx. INSIDE CITY, LHM TSP	
13io. STREET AND NUMBER		13dx. COUNTY		13io. CITY			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5739

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 08767 CERTIFICATE OF DEATH 08751 </div>									
1. DECEASED NAME (Type or print) First Middle Last Elsie M. Bugher					2a. DATE OF DEATH Month Day Year 6 3 69			2b. HOUR 5:30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 18 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Shilohville, Mo.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Boone County, Mo.			
10. CITY OR TOWN OF DEATH Lewistown, Mo.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Boone County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Mo.		13b. COUNTY Boone County		13c. CITY OR TOWN Lewistown, Mo.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6818 York Rd	
14. FATHER'S NAME First Middle Last ALBERT BUSHFIELD				15. MOTHER'S MAIDEN NAME First Middle Last EVA RUNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 305-0988		17. INFORMANT THOMAS W. BUGHER			Address SAME AS #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 5739 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-3, 1969, to 6-3, 1969, that (I) (we) last saw the deceased alive on 6-3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Leon Lewitsky				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED June 3, 1969			
22d. PHYSICIAN'S NAME (Type) LEON LEWITSKY, MD				22e. ADDRESS MT RAINIER, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JUNE 4, 1969		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND			
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD				25a. REC'D BY REGISTRAR JUN 9 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08768

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08762

1. DECEASED-NAME (Type or Print) OLA LOUISE BUTLER			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 18 Year 1969			2b. HOUR 10.40		
3. SEX F	4. RACE W	5. DATE OF BIRTH Aug. 17, 1930	6. AGE (in years last birthday) 38 YRS	IF UNDER 1 YEAR MONTHS 38 DAYS	IF UNDER 24 HRS HOURS 38 MIN.	2c. DATE PRONOUNCED DEAD 6/18/69 Month 6 Day 18 Year 1969		
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Princes Georges		
10. CITY OR TOWN OF DEATH Bradbury Hgts.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A.A.F.B.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE Md.		13b. COUNTY Prince George		13c. CITY OR TOWN Bradbury Hgts		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 5210 T St. S.E.
14. FATHER'S NAME First George H. Middle Oliver Last				15. MOTHER'S MAIDEN NAME First Ola Middle Moore Last				ADDRESS Bradbury, Hgts, Md.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Charles A. Butler				ADDRESS 5210 T, St. S.E.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull - Locusts Brain DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema & Congestive Failure DUE TO, OR AS A CONSEQUENCE OF (c) Gunshot wound								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dayton O Watkins		EXAMINER'S NAME (Type) DAYTON O WATKINS		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6-19-69		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/22/69		23c. NAME OF CEMETERY OR CREMATORY Oliver Cemetery		23d. LOCATION (City or Town) (County) (State) Pine Level, N. C.		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home, Suitland, Md				25a. REC'D BY REGISTRAR JUN 25 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Item 7 Filed 6/16/69
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08763

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year MATED <input type="checkbox"/> 6-4-69 12:00am M		2b HOUR
Catherine Virginia Byrne							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR
Female	White	8-24-1902	66 YRS		6 4 69 19 2:00am M		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		Mo.
Virginia		USA			Prince George's		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital					
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Prince George's		Bowie		2611 Kennison Lane	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
James Nash					Naomi Smallwood		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS			
No				Betty M. Kinser 2611 Kennison La., Bowie, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> (b) <u>over 30min.</u> DUE TO, OR AS A CONSEQUENCE OF <u>over 5 yrs.</u> (c) <u>over 5 yrs.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Gout - over 1 yr.</u>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				6-4-69	
John Kehoe MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Riverdale, Md.		ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Jun. 6, 1969		Annandale Methodist		Annandale, Virginia	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Cunningham Funeral Home, Inc. Alexandria, Va.				JUN 10 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

08770		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08764	
Item #6, Film 414 7/7/69 km		CERTIFICATE OF DEATH			
1 DECEASED NAME (Type or print) GUYN A. CALKINS		2a DATE OF DEATH Month 23 Day 1969 Year		2b HOUR 1A M	
3. SEX MALE	4 RACE WHITE	5. DATE OF BIRTH 12-4-1888		6 AGE (In years last birthday) 80 YRS.	7 UNDER YEAR MONTHS 8 UNDER 24 HRS DAYS HOURS M N
7a. BIRTHPLACE (State or foreign country) CONN.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH PRINCE GEORGES, Md.		
10. CITY OR TOWN OF DEATH GREENBELT	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREENBELT CONV. CENTER		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TOOL MAKER	12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b COUNTY FAIRVIEW	13c CITY OR TOWN LAUREL	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 13222 SANTA ANITA RD	
14. FATHER'S NAME First Middle Last HENRY CALKINS	15. MOTHER'S MAIDEN NAME First Middle Last CARRIE CURTISS				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO. 043-10-2689A	17 INFORMANT Mrs. Calkins Brown		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1970 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Primary: G I or pulmonary (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 HOURS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION None		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June 19th , 19 69 , to June 23rd , 19 69 , that (I) (we) lost saw the deceased alive on June 22nd , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Til Bergermann		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-23-69	
22d. PHYSICIAN'S NAME (Type) TIL BERGERMANN		22e. ADDRESS GREENBELT PROF BUILDING, GREENBELT, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) June 26, 1969		23b. DATE June 26, 1969		23c. NAME OF CEMETERY OR CREMATORY Fairview	
23d. LOCATION (City or Town) (County) (State) New Britain Conn.		23e. REC'D BY REGISTRAR JUL 2 1969		23f. REGISTRAR'S SIGNATURE Charles Judge	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
EVA LEE CAMPBELL						JUN 26 69		2:25 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
FEMALE		CAUCASIAN		24 JULY 1875		93 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
GA		U.S.A.				PRINCE GEORGE		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
ANDREWS AFB		MALCOLM GROW USAFHOSP		HOUSEWIFE		NA			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
D.C.		D.C.		BOLLING AFB				27 WESTOVER AVE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
JAMES THOMASSON			AMANDA FRANCES BLALOCK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
NO						WILLIAM B CAMPBELL SAME AS ITEM #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery</u>									30 MIN
4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD</u>									30 YRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from 10 Jun 1969, to 26 Jun 1969, that (X) (we) last saw the deceased alive on 26 Jun 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Leonard V. Farber</u> DEGREE					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 26 Jun 69		
22d. PHYSICIAN'S NAME (Type) LEONARD FARBER CAPT USAF MC					22e. ADDRESS MALCOLM GROW USAFHOSP ANDREWS AFB				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/29/69		Carrollton Cemetery		Carrollton Georgia			
24. FUNERAL DIRECTOR ROBERT E WILHEIM FUNERAL HOME 4308 SUTTIAND ROAD, SUTTIAND, MARYLAND					25a. REC'D BY REGISTRAR JUN 30 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Step 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>08772</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>08766</div>													
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		<input type="checkbox"/> Month <input checked="" type="checkbox"/> 6 12 1969		2b HOUR 1:00 a.m.	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		7c DATE PRONOUNCED DEAD		2d HOUR 1:40 a.m.	
Female		White		16 Sept 1928		40 YRS.				Month 6 Day 12 Year 1969			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH						Md	
New York		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George							
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George Hosp		Housewife		Own Home							
13a USUA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b COUNTRY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER					
Md.		Prince George		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13114 Oval Lane					
4 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Last	
William		Aubrey		Elvira		Thomas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS							
no		123 20 1335		Edward F. Cangeme		Same as # 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last													
(b) Compound skull fractures										Min			
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
		1:00 PM 6 12 1969		Pedestrian struck by car.									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town		County		State			
		Street-Rt 3 near rt 197,		Bowie		Prince George Co.		Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:													
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED									
John Kende, M.D., Riverdale				6-14-69									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)			
Burial		6/16/69		Ft. Lincoln		Colmar Manor P.G.		Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.								JUN 19 1969		James Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
08773									
08767									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Richard			W. Carroll			Month 6 Day 8 Year 69			12:45M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Male		Negro		9/24/19		49 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Wash., D. C.		USA				Prince Georges Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Glenn Dale, Md.		Glenn Dale Hospital		Laborer		--			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
D.C.				Wash., D.C.				820 New Jersey Ave., N.W.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William Carroll			Annie Berry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes		1942-1945		579-18-2927 Decedent					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive pulmonary embolism, main right pulmonary artery								sudden	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c) Right femoral artery thrombophlebitis								6 mos.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Below knee amputation, right, for gangrene of right foot, 1/8/69; left thoracotomy with resection of lingula, left lung, for pulmonary abscess 5/67									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (a) (this hospital) attended the deceased from 8/11, 1967, to 6/8, 1969, that (b) (we) last saw the deceased alive on 6/8, 1969, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Moe Weiss						6/8/69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Moe Weiss, M.D.				Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6-13-69		Baltimore Nat. Cem.		Catoctinville Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Kollins		4339 - 1st St. PL. h.c.		JUN 16 1969		[Signature]			

4274

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08774

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08768

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Alvera			Carter			Month June Day 4 Year 1969			8:40A M				
3. SEX		4. RACE		5. DATE OF BIRTH			6 AGE (in years last birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS		
Female		Colored		01-10-10			59 YRS		MONTHS		DAYS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH						
Georgia		U.S.A.					Prince George's Md						
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly				Prince George's Gen. Hosp									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
MD				Prince George's		Laurel		YES <input type="checkbox"/> NO <input type="checkbox"/>		622 9th Street			
14 FATHER'S NAME First Middle Last						15 MOTHER'S MAIDEN NAME First Middle Last							
James Harris						Maria Gray							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17 INFORMANT Address							
						Fred Carter (Husband) Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) -Respiratory and Cardiac arrest													
DUE TO, OR AS A CONSEQUENCE OF													
(b) -Bronchiectasis													
DUE TO, OR AS A CONSEQUENCE OF													
(c) -Atrial Fibrillation													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:(a)													
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. .9			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.			City or Town County State				
22a. I certify that XX (this hospital) attended the deceased from June 2, 19 69, to June 4, 19 69, that XX (we) lost saw the deceased alive on June 4, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED				
L. LOUIS BENTOLILA, M.D.						22e. ADDRESS Prince George's General Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			6/9/69		Mt. Zion Cemetery			Bacontown, P. Geor. Md.					
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR				
George R. Snowden						Rockville			25b. REGISTRAR'S SIGNATURE				
						JUN 10 1969			J. Charles Jones				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										8417																					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08769																					
1 DECEASED-NAME (Type or Print)			First Ernest			Middle Albert			Last Cashwell			2a DATE KNOWN OF DEATH		Month 6		Day 9		Year 1969		2b HOUR		14:45am									
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH		2c DATE PRONOUNCED DEAD		Month 6		Day 9		Year 1969		14:45am							
Male		Negro		4-22-1906		63 YRS		Virginia		USA		WIDOWED		Prince George's		6		9		69		14:45am		M							
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b KIND OF BUSINESS OR INDUSTRY																			
Cheverly				Prince George Hospital																											
13a USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?				13e STREET AND NUMBER															
Maryland				Prince George's				Lanham				YES <input type="checkbox"/> NO <input type="checkbox"/>				8811 Keewatin Rd.															
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME				16a WAS DECEASED EVER IN U.S. ARMED FORCES?				16b SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
Ben Cashwell				Mattie Cashwell												Ernest Cashwell				8811 KEEWATIN RD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 1 DEATH WAS CAUSED BY:																															
IMMEDIATE CAUSE (a) Shock																															
DUE TO, OR AS A CONSEQUENCE OF Enteritis																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																															
DUE TO, OR AS A CONSEQUENCE OF																															
(c) etiology undetermined																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																															
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY?											
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b TIME OF INJURY Month, Day, Year										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
										19 P.M.																					
21d INJURY OCCURRED										21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f LOCATION Street or RFD No		City or Town		County		State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																															
22a I certify that I took charge of the remains described above, held on death resulted from.										Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																					
Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																															
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b DATE SIGNED											
EXAMINER'S NAME (Type)										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										6-9-69											
John Kehoe M.D. Riverdale, Md.										ADDRESS (Street, city, town, or county)																					
23a BURIAL, CREMATION REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or town) (County) (State)	
6-12-69																				Clifford, Va.											
24. FUNERAL DIRECTOR										ADDRESS										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE	
Prosser 389 R.I. Ave. NW																				JUN 11 1969										Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 19. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15M. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

08776

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08770

Item #1, taken from MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First Middle Last Guy R Caviness Sr.		2a. DATE KNOWN OF DEATH Month Day Year 6-23-69 19 12:40am		2b. HOUR
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7-15-1918	6. AGE (In years last birthday) 50 YRS	2c. DATE PRONOUNCED DEAD Month Day Year 6 23 69 19 12:55am
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George Hospital		9. COUNTY OF DEATH Prince George's Md
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Prince George's Hillcrest Hgts.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic
14. FATHER'S NAME First Middle Last Andy Caviness		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Reed		12b. KIND OF BUSINESS OR INDUSTRY Automobile
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W W 2		16b. SOCIAL SECURITY NO		13c. STREET AND NUMBER 3302 Curtis Drive
17. INFORMANT ADDRESS Evelyn Caviness, 3302-Hillcrest Hgts, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 6-23-69
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE 6/26/69		23c. NAME OF CEMETERY OR CREMATORY Washington National
23d. LOCATION (City or Town) (County) (State) Suitland, Md.		24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308-Suitland, Rd., Suitland, Md.		
25a. REC'D BY REGISTRAR DATE JUN 30 1969		25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
08777												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Felix			NMI		Cecchetti				Month 06 Day 20 Year 69		8:50 PM	
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR	
Male			Caucasian			05-25-97			72 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			
Italy			U.S.A.						Prince Georges County, Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPAT ON (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale			Eugene Leland Mem. Hosp.			Retired			U.S. Government			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. CITY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince Georges			College Pk.					4808 Berwyn Road	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME First Middle Last			
Ralph			Cecchetti						Rose A Cecchetti College Park, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT Address						
no						Rose A Cecchetti College Park, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Failure</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Thrombosis R = L Hemiplegia</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary atherosclerotic cardiovascular disease</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 6/20/69, 1969, to 6/20/69, 1969, that (I) (we) last saw the deceased alive on 6/20/69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			
W.L. Etienne			6/20/69			W.L. ETIENNE			College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or town) (County) (State)			
Burial			June 24, 1969			Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			DATE			
F. Gasch's Sons			Hyattsville, Md.			JUN 25 1969			Charles J. J...			

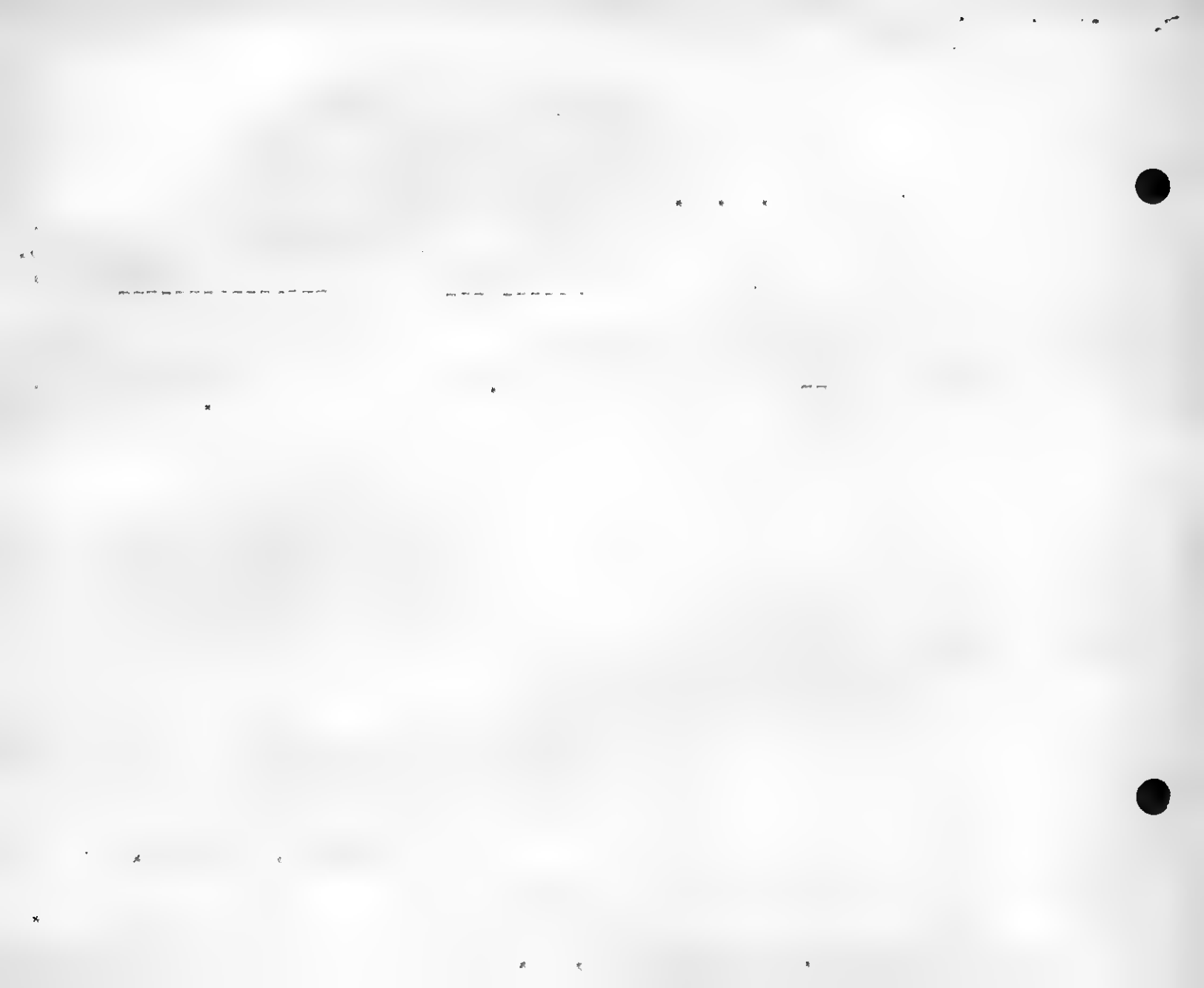


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 30 days after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08778									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
Louis		Henry		Chaney, S.R.		Month		Day	
						June		3, 1969	
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (In years lost birthday)		7b. HOUR	
Male		White		12-13-03		65 YRS.		3:10 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S. A.				Prince George's		Md.	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp.		Bus Driver		Public Transit Co.			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
MD		Prince George's		Cheltenham Hyattsville		Cheltenham, Md			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Joseph		Samuel		Chaney		Carrie		Mabel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		RFD Box 2343		Upper Marlboro, Md. 20870	
No				Mrs. Ada Mabel Parker-					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary undetermined</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med col examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> hot white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <u>Haluk Boneval</u> (this hospital) attended the deceased from <u>May 21</u> , 19 <u>69</u> , to <u>June 3</u> , 19 <u>69</u> , that <u>we</u> lost saw the deceased alive on <u>June 3</u> , 19 <u>69</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (we) (did) <u>not</u> view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
Haluk Boneval, M.D.		6.3.69		Haluk Boneval, M.D.		Cheverly, Maryland.		Prince George's General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/6/69		Smithville Cemetery		Dunkirk Calvert Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ritchie Bros. Upper Marlboro, Md. 20870		JUN 5 1969		JUN 5 1969		Charles Judge			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08779		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08773	
Items#23a,b, Film 444 7/7/69 km					
1 DECEASED NAME (Type or print)		First Middle Last		2a. DATE OF DEATH	
Norma		C. Churchville		June Month 28 Day 1969 Year 0330 HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		Caucasian		Feb. 1, 1922	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (In years last birthday)	
Mass.		U.S.		47 YRS.	
9. COUNTY OF DEATH		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12b. KIND OF BUSINESS OR INDUSTRY	
Prince Georges				Homemaker	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Camp Springs		Malcolm Grow USAF		Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13c. STREET AND NUMBER	
STATE Virginia		Alexandria		5375 Duke St.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
Charles		Charlotte		Munsil	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		7 INFORMANT Address	
No		021-18-6162		Husband- Louis J. Churchville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)					
PART 1. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) Cardiac Arrest					
DUE TO, OR AS A CONSEQUENCE OF Acute Lukemia					
DUE TO, OR AS A CONSEQUENCE OF Myeloid Metaplasia					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
Relapsing Polychondritis (was related to "C" above)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
none				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY; OFFICE, BUILDING, ETC.)		21f. LOCAT ON	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June 1968, to 28 June 1969, that (I) (we) last saw the deceased alive on 27 June 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE		22c. DATE SIGNED			
W.F. Berger, M.D.		28 June 1969			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
W. F. Berger M.D.		Malcolm Grow USAF Clinical Center			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		July 7 1969		Arlington National	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Della Backlick Rd. Springfield, Va.		JUL 2 1969		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1341

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR	
FRED						CLARK		Month 6 Day 19 Year 1968		M	
3. SEX		4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 FINDER 1 YEAR		IF UNDER 24 HRS	
male		white		12-16-95		73 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH					
New York		USA				Prince George				Md.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
ADELPHI		1801 Metzgerott Rd									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) STATE		13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LIMITS?		13e STREET AND NUMBER			
MD		BALTIMORE		Tetoma Box		YES <input type="checkbox"/> NO <input type="checkbox"/>		506 tulip Ave T.P.			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bt and pneumonia</u>										24 hours	
DUE TO, OR AS, A CONSEQUENCE OF (b) <u>Malnutrition</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Carcinoma of rectum + urinary bladder metastasis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY		20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>6-15, 1967</u> , to <u>6-17, 1967</u> , that (I) <u>(saw)</u> last saw the deceased alive on <u>6-17, 1967</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYS		MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED			
<u>Morton A. Itschler</u>								6-19-69			
22d PHYSICIAN'S NAME (Type)		22e ADDRESS									
Morton A. Itschler, MD		9205-North Washington Ave									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
<u>6/27/69</u>		<u>6/27/69</u>		<u>St. Mary's School</u>		<u>Baltimore</u>		<u>Md.</u>			
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
				DATE <u>8 1969</u>		<u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers - Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

4109

1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH	
Lemma		Cogar		June		Month 14		Day 69 Year 6:35a M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
female		white		Feb. 11, 1898		71 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Georgia		U. S. A.				Prince George's Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's General		Designer		Florist			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		3d INS OF CITY, J.M.T.S?		13e STREET AND NUMBER	
Md.		Prince George's		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4705 Edmonston Avenue	
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
William F. Thomason		Rebecca Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown))		16b SOCIAL SECURITY NO		17 INFORMANT		6907 Shepherd Street Hyattsville, Maryland			
no		214 36 2691		Lillian F. Betts					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute thrombosis right coronary artery</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease, severe</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (p)									
<u>Pulmonary emboli, Right ventricular failure, old cerebral infarction, old wounds, tuberculosis, left ventricular failure, etc.</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
6/14/69		Cardiac arrest - insertion of pacemaker		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B)					
		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State					
22a I certify that (I) (the coroner) attended the deceased from <u>5/31</u> , 19 <u>69</u> , to <u>June 14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)					
Frederick H. Wilhelm, M.D.		6/14/69		Frederick H. Wilhelm, M.D.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		23e REGISTRAR'S SIGNATURE	
Burial		6/17/69		Ft. Lincoln		Colmar Manor P.G. Md.		Francis Gasch's Sons Hyattsville, Md.	
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
		JUN 19 1969		Charles Judge					

VR 45M

1519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08782

Item 23 Film 413 6/23/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08776

1. DECEASED-NAME (Type or print) HAROLD A Colbert			2a. DATE OF DEATH Month 6 Day 11 Year 1969			2b. HOUR 10:15 M	
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 10-12-12		6. AGE (In years last birthday) 56 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CIT ZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges County Md.	
10. CITY OR TOWN-OF DEATH Chinton md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chinton comm Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Jesuit Middle Colbert		15. MOTHER'S MAIDEN NAME First Green Middle Livingston Last RD		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 213-12-1514		17. INFORMANT Mrs. Janie Colbert Address 12415 Livingston Rd Chapel Hill, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE CARCINOMATOSIS 4 WKS DUE TO, OR AS A CONSEQUENCE OF (c) GASTRIC CA (MULTIPLE-POLE, REC. VASK.)							
PART 2. OTHER SIGNIF. COND. CONTRIB. TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR COND. GIVEN IN PART 1 (a) LIVER FAILURE							
19a. DATE OF OPERATION OCT '68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GASTRIC CA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from June 1st, 1966 to 6/11/69 , that (I) (we) lost saw the deceased alive on 6/11/69 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE ROST. W. MERKLE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/11/69	
22d. PHYSICIAN'S NAME (Type) ROST. W. MERKLE M.D.		22e. ADDRESS CLINTON MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-17-69		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery,		23d. LOCATION (City or Town) (County) (State) Chapel Hill Md.	
24. FUNERAL DIRECTOR John T. Rhines & Co.,,		ADDRESS 3030-12th St/N.E. D.C.		25a. REC'D BY REGISTRAR 16 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4123

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
DOROTHY		MARIE		COLEY				June Month 13 ^{Day} 1969		4:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS		8. UNDER 24 HRS HOURS MIN	
Female		White		Dec. 20, 1912		56 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U. S. A.				Prince George				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USJA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince George Hospital		Sales Clerk		Drug Store					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		P. G.		Beltsville				3517 Susquehanna Drive			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Phillip		S.		Pettit				Emma		Lee Bryan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no						Joan Cheswoir		Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchopneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1969</u> , to <u>June 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death											
22b. SIGNATURE		22c. DATE SIGNED		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		6/14/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS		22h. ADDRESS			
Robert Kelley, M.D.		Prince George General Hospital									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		6/17/69		Ft. Lincoln		Colmar Manor		P. G.		Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE			
Francis Gasch's Sons		Hyattsville, Md.		JUN 18 1969		Francis Judge					

FOR STATE
HEALTH DEPT

08784

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08779

1. DECEASED-NAME (Type or Print) AMANDA HENRIETTA COUNSELMAN			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year June, 19, 1969			2b. HOUR OF DEATH 9:30 A.M.		
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH 7-17-1881	6. AGE (In years last birthday) 87 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month June Day 19 Year 1969		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George County Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY Dress Shop	
13a. USUA. RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George			13c. CITY OR TOWN Hyattsville		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1206 Chillum Manor Rd.					
14. FATHER'S NAME First Middle Last William Counselman			15. MOTHER'S MAIDEN NAME First Middle Last Julia Anne Offutt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. J.A. Looney ADDRESS Same as Item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) General Debility due to old age - Arteriosclerosis Emphysema DUE TO, OR AS A CONSEQUENCE OF (b) Wound infection internally Pinned DUE TO, OR AS A CONSEQUENCE OF (c) Wound infection internally Pinned Hip								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Wound infection internally Pinned Hip								
19a. DATE OF OPERATION 4-4-69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Hip			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fracture Hip turning in bed				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Nursing home		21f. LOCATION Street or R.F.D. No. City or Town State Sacred Heart Nursing Home Rockville Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dayton Watkins			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 6-20-69		
EXAMINER'S NAME (Type) DAYTON O. WATKINS			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county) Prince George Co.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-21-69		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. RECEIVED BY REG. STRAP DATE JUN 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove garbage papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

185X

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08785		CERTIFICATE OF DEATH						08780	
1 DECEASED-NAME (Type or print) CHACY CLENDEN COX			2a. DATE OF DEATH Month JUNE Day 30 Year 1969			2b. HOUR 10A			
3 SEX Male		4 RACE White		5. DATE OF BIRTH AUG. 21, 1911		6 AGE (In years lost birthday) 57 YRS.		7 IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a BIRTHPLACE (State or foreign country) W. VA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PR. GEORGES Md			
10. CITY OR TOWN OF DEATH UPPER MARLBORO		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7601 OSBORNE RD. LOGGING-LUMBERING		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BUSINESS		12b KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE MD.		13b COUNTY PR. GEO.		13c INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET AND NUMBER 7601 OSBORNE RD.			
14 FATHER'S NAME First Middle Last CHARLES W. COX			15 MOTHER'S MAIDEN NAME First Middle Last MARY JANE BRAGG						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO. 577-30-2635		17 INFORMANT WIFE JEANETTE COX		Address 7601 OSBORNE RD. UPPER MARLBORO			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) TERMINAL BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED CARCINOMATOSIS - DUE TO, OR AS A CONSEQUENCE OF (c) SPINE - RIBS CARCINOMA OF PROSTATE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 MRS. 1 1/2 YRS 4 1/2 YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, specify medical condition) None		21b. TIME OF INJURY HOUR A.M. None Month None Day None Year 1969		21c. HOW INJURY OCCURRED (State nature of injury in Part 1 or Part 2, Item 18.) None					
21d. INJURY OCCURRED Where None at work None		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) None		21f. LOCATION Street or R.F.D. No. City or Town County State None					
22a. I certify that (I) (this hospital) attended the deceased from SEP. 19 55 until present and that (I) lost saw the deceased alive on JUNE 30 1969 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (a) (b) (c) view the body after death.									
22b. SIGNATURE Arthur Shaver Jr. MD		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED June 30 1969					
22d. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. MD		22e. ADDRESS 2408 BRANCH AVE. CHANTON, MD. 20735							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/3/69		23c. NAME OF CEMETERY OR CREMATORY Friendship Meth. Com.		23d. LOCATION (City or Town) (County) (State) Friendship A.A. Md.			
24. FUNERAL DIRECTOR Ritchie Bros. Funl Home-Md. 20870:		25a. REC'D BY REGISTRAR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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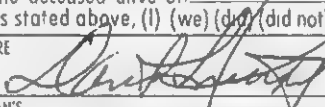

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08786 CERTIFICATE OF DEATH 08781									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Robert L. Cox						June 28 1969			12:40a M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
male		white		Jan. 24, 1903		66 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Wash. D. C.		U. S. A.				Prince George's		Md	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George's General			Retired U. S. Govt.			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Md.			Montgomery		Silver Spring				9408 Garwood St.
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
John F. Cox			ISABELLA A. Mulligan						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT Address				
no			220-42-2989		Miss Helen V. Cox Same as #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive intrapulmonary hemorrhage</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemorrhagic diathesis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septicemia</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 25, 1969</u> , to <u>June 28, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. xx									
22b. SIGNATURE			22c. DATE SIGNED						
SAMUEL J. V. SUGAR MD			6/29/69						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
SAMUEL J. V. SUGAR MD			4637 EASTERN AVE WASH, DC 20018						
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-2-69		Mt. Olivet Cemetery		Washington D. C.			
24. FUNERAL DIRECTOR			25a. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Francis J. Collins			JUL 2 1969			[Signature]			
500 Univ. Blvd. W. Silver Spring, Maryland.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First WILLIAM	Middle GRANT	Last GREEN	2a. DATE OF DEATH JUN Month 1 Day 69 Year			2b. HOUR 1:24 M
3 SEX MALE		4 RACE NEGROID		5. DATE OF BIRTH 6 APR 1906		6 AGE (In years last birthday) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) PENNA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S			
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAF HOSP		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) MESS SUPV AF		12b. KIND OF BUSINESS OR INDUSTRY RETIRED			
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE PA		13b. COUNTY SOMERSET		13c. CITY OR TOWN H OOVERVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last WILLIAM GEORGE GREEN			15. MOTHER'S M A D E N NAME First Middle Last Frankie WILLIAMSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) YES		16b. SOCIAL SECURITY NO 278-36-5107		17. INFORMANT ANNIE D. GREEN		1911 SAVANNAH TERRACE SE WASHINGTON, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF COLON WITH DISTAL METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) 1964								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEPT 1968	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 1964		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENO CA OF COLON REMOVED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 1 May , 19 69 , to 1 Jun , 19 69 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 2 JUN 69			
22d. PHYSICIAN'S NAME (Type) DAVID S. ROSENTHAL MAJ USAF MC				22e. ADDRESS MALCOLM GROW USAF HOSPITAL ANDREWS AFB MD					
23a. BURIAL - CREMATION REMOVAL (Specify) Burial		23b. DATE 6-4-69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) Arlington Virginia		(County)	(State)
24. FUNERAL DIRECTOR W. W. Chamber G. 517-11, 4th E.				25a. REC'D BY REGISTRAR JUN 5 1969		25b. REGISTRAR'S SIGNATURE 			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08788

08783

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-10-1. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		<input type="checkbox"/> Month	Day	Year	2b HOUR
Annunziato		G.	Crescenti		2a DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> 6	28	1969	0:15 M
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day
M	W	28 Mar., 1914		55 YRS	MONTHS	DAYS	6		28	1969
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Italy		U S A				Prince George Md				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Glendale		Glendale Hosital		Priest		catholic church				
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
New Jersey		Mt. Clair		Mt. Clair		YES <input type="checkbox"/> NO <input type="checkbox"/>		94 Pine St.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Romano		Crescenti			Concetta		Silipigni			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
no		150 36 7652		Rose DeLorenzo		Irvington New Jersey.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Minutes
Heart failure										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
(b)										
Advanced arteriosclerotic heart disease										yrs.
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOURLY AM PM 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town		County		State
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b DATE SIGNED		ADDRESS (Street, city, town, or county)				
John Kehoe, M.D.		Riverdale		6-29-69						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		7/2/1969		Holy Sepulchre Cemetery		Newark Essex				N J
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
F. Gasch's Sons				Hyattsville, Md.		JUL 1 1969		J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4123

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08789 CERTIFICATE OF DEATH 08784										
1. DECEASED-NAME (Type or print) <i>Virginia G. Cunningham</i>			2a. DATE OF DEATH Month <i>6</i> Day <i>17</i> Year <i>1969</i>			2b. HOUR <i>2:30 PM</i>				
3 SEX <i>Female</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>1-13-1880</i>		6 AGE (n years last birthday) <i>89</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) <i>Ill</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Price George</i>				
10. CITY OR TOWN OF DEATH <i>Lanham Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Virginia Gardens</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i> COUNTY <i>Price</i>			13c. CITY OR TOWN <i>Lanham</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>2920 Sarragon Lane</i>			
14. FATHER'S NAME First <i>John</i> Middle <i>Anthony</i> Last <i>Smith</i>			15. MOTHER'S MAIDEN NAME First <i>Josephine</i> Middle <i>Houston</i> Last <i>Smith</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown <input type="checkbox"/>			16b. SOCIAL SECURITY NO. <i>4123</i>		17. INFORMANT <i>Ruth V. Miles</i> Address <i>Price, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>										
4123 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) <i>Chronic Bronchitis</i>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <i>Heart Failure</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>6-19</i> , 19 <i>62</i> , to <i>6-17</i> , 19 <i>64</i> , that (I) (we) lost saw the deceased alive on <i>6-19</i> , 19 <i>64</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Leon Louiey, MD</i>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <i>Leon Louiey, MD</i>					22e. ADDRESS <i>Lanham, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>June 23, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>		23d. LOCATION (City or Town) <i>South Hutchinson</i> (County) <i>Kansas</i> (State)				
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>					25a. RECD BY REGISTRAR <i>JUN 23 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08790		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08785		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Mary Jane Dawes					Month	Day	Year	
6		25		69		10:45 PM		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	
Female	Caucasian	08-01-81		87 YRS.				
7a BIRTH-PLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
No. Carleton	USA			Prince Georges Md				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
cheverly	GCH. ECF		Housewife		Home			
13a. USJAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
md.	P.D.	Cap. Heights		5405 Byer Street				
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	
	?	Williams		Thelma A Moore				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT				
No		215-56-748		Full Audish 5405 Byer ST				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
<u>Coronary Arteriosclerotic disease</u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
		P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
J. B. Solman MD				22e. ADDRESS				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6-28-69	F.T. Lincoln Cem		Baltimore Md			
24. FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE		
Howard E. Wickham		4308 Suitland Rd		June 30 1969		June 30 1969		
		Suitland Md						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08791

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08786

1. DECEASED-NAME (Type or print) First Middle Last Ruth Lawrence Dawson			2a. DATE OF DEATH Month Day Year June 26 1969		2b. HOUR 0300A M
3. SEX Feminine	4. RACE Caucasian	5. DATE OF BIRTH Feb 12 1904		6. AGE (In years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTH-PLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Prince Georges County Md.		
10. CITY OR TOWN OF DEATH Andrews AFB, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland	13b. CITY OR TOWN Charles	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 15 Shiloh Church Road		
14. FATHER'S NAME First Middle Last Benjamin Edward Lawrence	15. MOTHER'S MAIDEN NAME First Middle Last Eva Ann Clark				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No	16b. SOCIAL SECURITY NO 228 18 8455	17. INFORMANT Address Robert E. Paden 15 Shiloh Ch.Rd. Bryans RD. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>567.0</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia rt lower lobe</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Postoperative state, small bowel resection</u>					
19a. DATE OF OPERATION <u>23 June 69</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Small bowel fistula</u>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>19 April</u> , 19 <u>69</u> , to <u>26 June</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>26 June</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John M. Clarke, MD</u>		22c. DATE SIGNED <u>26 June 69</u>			
22d. PHYSICIAN'S NAME (Type) John M. Clarke		22e. ADDRESS Malcolm Grow Hosp. Andrews AFB, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-30-69	23c. NAME OF CEMETERY OR CREMATORY Oak Grove	23d. LOCATION (City or Town) (County) (State) Portsmouth Va.		
24. FUNERAL DIRECTOR Hunt Funeral Home Waldorf, Md.		25a. REC'D BY REGISTRAR DATE JUN 30 1969	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

08792

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08787

Item 6 Film 6413 6/16/69 kk

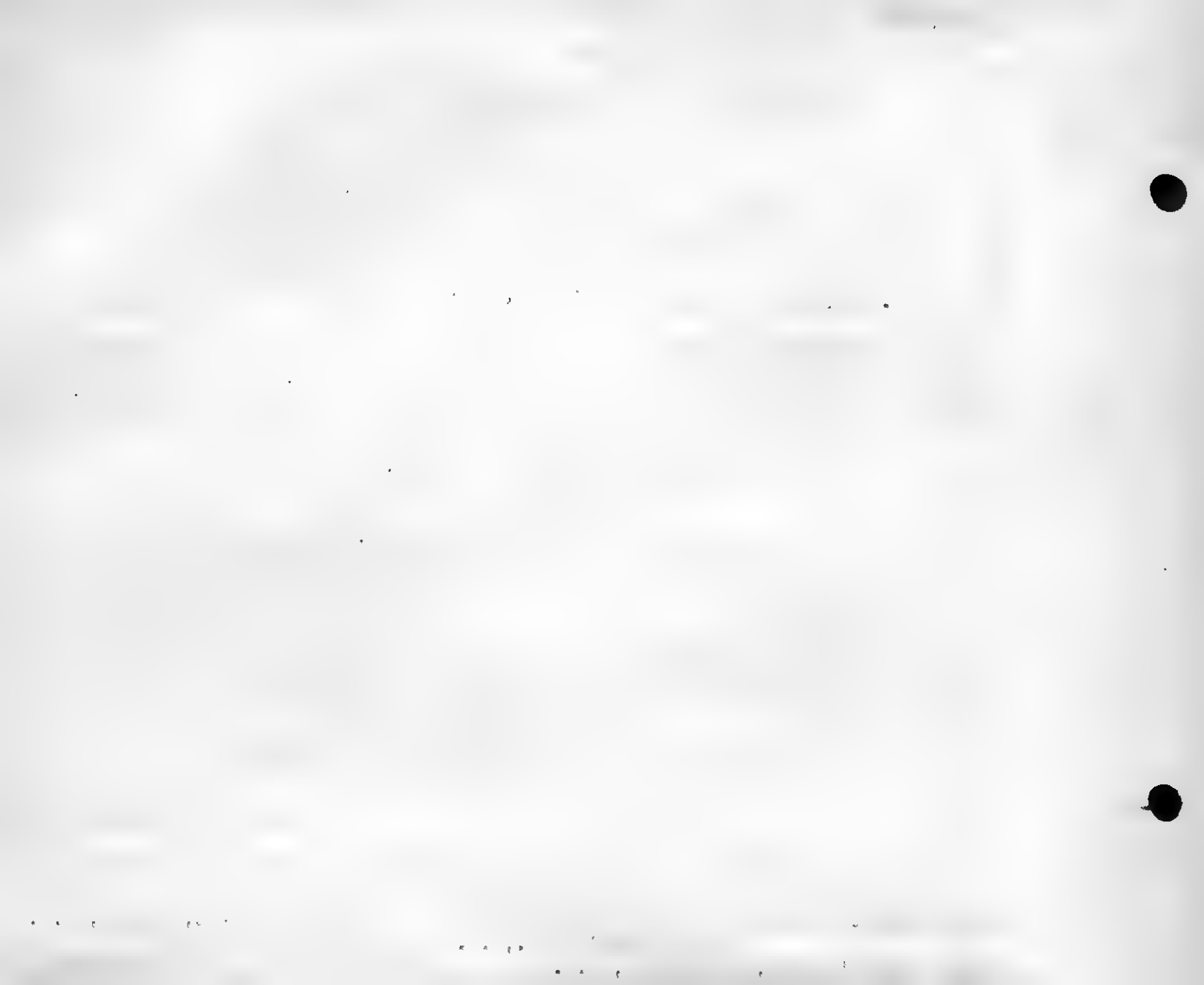
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) SYLVIO RIBEIRO DE CARVALHO			2a. DATE OF DEATH JUN Month 8 Day 69 Year		2b. HOUR 1115 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 8-5-1904		6. AGE (In years last birthday) 64 YRS.	7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Brazil		7b. CITIZEN OF WHAT COUNTRY? Brazil		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Prince George		10. CITY OR TOWN OF DEATH Andrews AFB			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) Ambassador		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USJA. RESIDENCE (Where deceased lived, if not in hospital admission) STATE S. America		13b. COUNTY Brazil		13c. CITY OR TOWN Rio de Janeiro	
14. FATHER'S NAME Zacarias Gois De Carvalho		15. MOTHER'S M A DEN NAME Eugenia Ribeiro De Carvalho		16. WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes give war or dates of service)	
17. INFORMANT Mr Oino Preto Brazilian Embassy D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) to previous cardiac arrest & Pulmonary insufficiency. DUE TO, OR AS A CONSEQUENCE OF insufficiency. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause: (b) Chronic pulmonary insufficiency DUE TO, OR AS A CONSEQUENCE OF secondary to pulmonary (c) fibrosis etiology unknown.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 (Item 18))	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that 1 (this hospital) attended the deceased from 30 May , 19 69 , to 8 Jun , 19 69 , that 1 (we) last saw the deceased alive on 8 Jun , 19 69 , and that in 1 (our) opinion death occurred on the date and hour and from the causes stated above, 1 (we) 1 (did) (did not) view the body after death.					
22b. SIGNATURE Michael S Goldstein DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED 8 Jun 69	
22d. PHYSICIAN'S NAME MICHAEL S GOLDSTEIN CAPT USAF MC				22e. ADDRESS MALCOLM GROW USAFHOSP ANDREWS AFB	
23a. B.J.R.A. CREMATION REMOVAL (Specify)		23b. DATE 6/10/69		23c. NAME OF CEMETERY OR CREMATORY Sao Joao Batista	
23d. LOCATION (City or Town) (County) (State) Burial/Transit		23e. LOCATION (City or Town) (County) (State) Rio de Janeiro, Brazil, S.A.		23f. LOCATION (City or Town) (County) (State) Rio de Janeiro, Brazil, S.A.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.		25a. REC'D BY REGISTRAR JUN 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

5177

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

08793

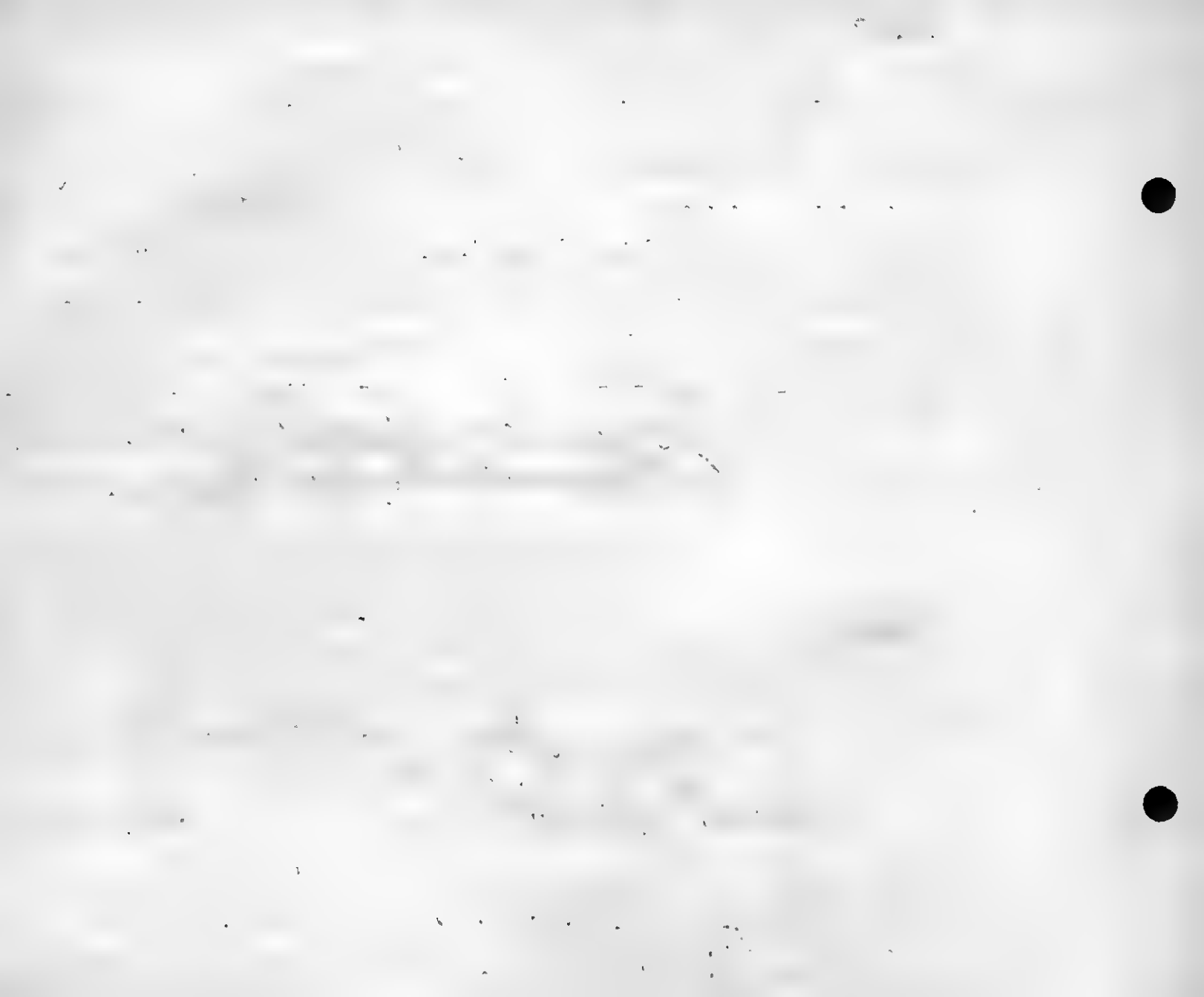
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08788

Item 23 Filed 15 8/11/69 kk

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Mary</i>			First <i>Mary</i>			Middle <i>Jane</i>			Last <i>Degen</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>6</i> Year <i>1969</i>			2b. HOUR <i>11:30</i> AM		
3 SEX <i>Female</i>			4. RACE <i>White</i>			5 DATE OF BIRTH <i>Oct. 9, 1880</i>			6 AGE (In years last birthday) <i>88</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7b BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Prince Georges</i>								
10. CITY OR TOWN OF DEATH <i>Cheverly</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>DOA Prince Georges Hosp.</i>			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <i>Housewife</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Own home</i>								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Prince Georges</i>			13c. CITY OR TOWN <i>Chillum</i>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>625 Sheraton St., Apt. 21</i>					
14 FATHER'S NAME First <i>John</i>			Middle <i>O'Donohue</i>			Last <i>unknown</i>			15 MOTHER'S MAIDEN NAME First <i>Rita A.</i>			Middle <i>Degen</i>			Last <i>Chillum, Md.</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>577-05-4084</i>			17 INFORMANT <i>(Daughter)</i>			Address <i>625 Sheraton St., Chillum, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY.																	
IMMEDIATE CAUSE (a) <i>4123</i>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) <i>Congestive Heart Failure</i>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) <i>Arteriosclerosis Heart Disease 10 years</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>5 June 1969</i> to <i>6 June 1969</i> , that (I) (we) last saw the deceased alive on <i>5 June 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Robert C. Haile</i>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>June 7 1969</i>								
22d. PHYSICIAN'S NAME (Type) <i>Robert C. Haile</i>			22e. ADDRESS <i>35 New York Avenue, N.W.</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>June 10 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C. (County) (State)</i>								
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>			ADDRESS <i>8434 Georgia Avenue, Silver Spring, Md.</i>			25a. REC'D BY REGISTRAR DATE <i>JUN 10 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 8 Film 414 7/1/69 kk										
CERTIFICATE OF DEATH										
08789										
1. DECEASED NAME (Type or print) First Middle Last George M Dixon					2a. DATE OF DEATH Month Day Year June 23 1969			2b. HOUR 4:41A M		
3 SEX Male		4 RACE White		5 DATE OF BIRTH Nov 25, 1895		6 AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md				
10. CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Gen. Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) D C Fireman		12b KIND OF BUSINESS OR INDUSTRY D C Government		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD			13b COUNTY Prince George's		13c CITY OR TOWN Riverdale		13d INSIDE CITY - H.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6705 Inghram Street	
14. FATHER'S NAME First Middle Last James Dixon					15 MOTHER'S M.A.D.E.N NAME First Middle Last Isabelle Lewis					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes			16b. SOCIAL SECURITY NO. W W I 578 48 5651		17. INFORMANT Address Juesie L. Dixon Riverdale, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus; Old cardiovascular disease</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (his hospital) attended the deceased from <u>Oct 18</u> , 19 <u>67</u> , to <u>4/16</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/16/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.										
22b. SIGNATURE <u>Julius Kauffman, M.D.</u>					22c. DATE SIGNED 6/23/69		22d. PHYSICIAN'S NAME (Type) Julius Kauffman, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 25, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.		25a. REC'D BY REGISTRAR JUN 27 1969		
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.					25b. REGISTRAR'S SIGNATURE W. L. Lander					

4/123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08795		CERTIFICATE OF DEATH						08790	
1 DECEASED NAME (Type or print)		First		Middle		Last		20 DATE OF DEATH	
Garnet		B.		EARLS		June 14		1969 12:05P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 IF UNDER YEAR	
Male		White		27 SEPT 1899		69 YRS		MONTHS DAYS HOURS MIN	
70 BIRTHPLACE (State or foreign country)		71 CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
ILLINOIS		U.S.				PRINCE GEORGE'S			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, DR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CHEVERLY		PRINCE GEORGE'S GEN HOSP		POST MASTER		U.S. POST OFFICE			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admittance) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY, TOWN?		13e. STREET AND NUMBER	
MARYLAND		PRINCE GEORGE'S		HYATTSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5340 CHESAPEAKE RD	
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
SHERMAN		EARLS		CORA		TUNADLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOC. SEC. NO.		17 INFORMANT		Address			
YES		W.W. II		219388851		ALICE D. LAPOTZ		SAME AS # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure								2 years	
4123 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease								several years	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Divergent atherosclerosis								2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 18, 1969, to May 27, 1969, that (I) (we) last saw the deceased alive on June 11, 1969, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE		DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		JOHANNES SAHAKIAN				22e. ADDRESS 6001 Cantonment Rd Cleveland OH			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		18 JUNE 1969		SOUTH CEMETERY		BASCO, ILLINOIS			
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. Chambers, Co. Riverdale, Ind.						JUN 18 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08796		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08791		
CERTIFICATE OF DEATH								
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b. HOUR
LELIE			VINCENT	ECK	June 13, 1969		11:15	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS
Male		White		April 1, 1927		42 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH		
Washington D. C.		U. S. A.				Prince George		Md.
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George Hospital		Ret. Plumber		Construction		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Md.		P. G.		Hillside				1219 51st Avenue
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME First Middle Last		
Frank			Eck	Annabell	Brown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address				
Yes		WW 11		577 32 1912 Frank Eck Same as #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral, severe</u>								
485x DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
<u>Diabetes mellitus.</u>								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1969</u> , to <u>June 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)				
<u>Robert Kelley</u>		6/14/69		Robert Kelley, M. D.				
22e ADDRESS		22f ADDRESS						
Prince George General Hospital		Prince George						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		6/16/69		Cedar Hill		Suitland Prince George		Md.
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Francis Gasch's Sons Hyattsville, Md.		JUN 19 1969		<u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
7/3/69 llw 08797									
CERTIFICATE OF DEATH									
08792									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Joseph I Eisenberg						June 26 1969			4:54 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		Cau.		6-21-88		81 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Poland		U.S.A.				Prince George's County Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR IND. STRY			
Hyattsville, Md		Hyattsville Nursing Home		Garment Worker		CLOTHING			
13a. U.S.A. RESIDENCE (Where deceased lived, if instit on Residence before admiss on) STATE		13b. CITY OR TOWN		13c. INS. DE CTY. LIMITS?		13e. STREET AND NUMBER			
Md		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1516 PAULA Dr.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
UNKNOWN			UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
No			087-03-5370			Mr Herman Bragman 1516 PAULA Dr. SSMD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY CARCINOMATOSIS</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 wks.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>PULMONARY EMPHYSEMA ; ARTERIOSCLEROTIC HEART DISEASE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 26 1969</u> to <u>JUNE 24 1969</u> , that (I) (we) last saw the deceased alive on <u>6-26-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Samuel A. Hillman MD</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>6-27-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>DR. SAMUEL A. HILLMAN</u>				22e. ADDRESS <u>8829 FLOWER AVE SILVER SPRING MD 20901</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/27/69		Beth El Cem.		PArAMUS, N.J.			
24. FUNERAL DIRECTOR <u>Shedley Funeral Home</u>				ADDRESS <u>42179THS-NU</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						DATE <u>11N 30 1969</u>		<u>Charles J. ...</u>	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-10-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 415 MARYLAND STATE DEPARTMENT OF HEALTH
7-31-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08798

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08793

1. DECEASED-NAME (Type or Print) Mary A. Emmanuelli			2a DATE KNOWN OF ESTI- DEATH MATED 6-8-69 17:30am M		
3 SEX Female	4 RACE White	5 DATE OF BIRTH 1/4/32	6 AGE (in years) 37 YRS	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN.
7b BIRTHPLACE (State or foreign country) Penn.		7c CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Clerk		9 COUNTY OF DEATH Prince Georges Md	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b COUNTY P. Geo.		13c CITY OR TOWN Cottage City	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3700 37th Place		12b KIND OF BUSINESS OR INDUSTRY Loan Co.	
14 FATHER'S NAME Robert A. Saul			15. MOTHER'S MAIDEN NAME Alpha Yeho		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 577 40 3271		17. INFORMANT Nelson E. Emmanuelli ADDRESS Same (Husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia, bilateral 185 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20 EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.		M.D.		22b. DATE SIGNED 6-9-69	
EXAMINER'S NAME (Type) John Kehoe M.D.		Riverdale, Md.		ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION, or other disposal Burial		23b DATE 6/12/69		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Maryland		25a REC'D BY REGISTRAR JUN 13 1969	
				25b REGISTRAR'S SIGNATURE John D. Judge	

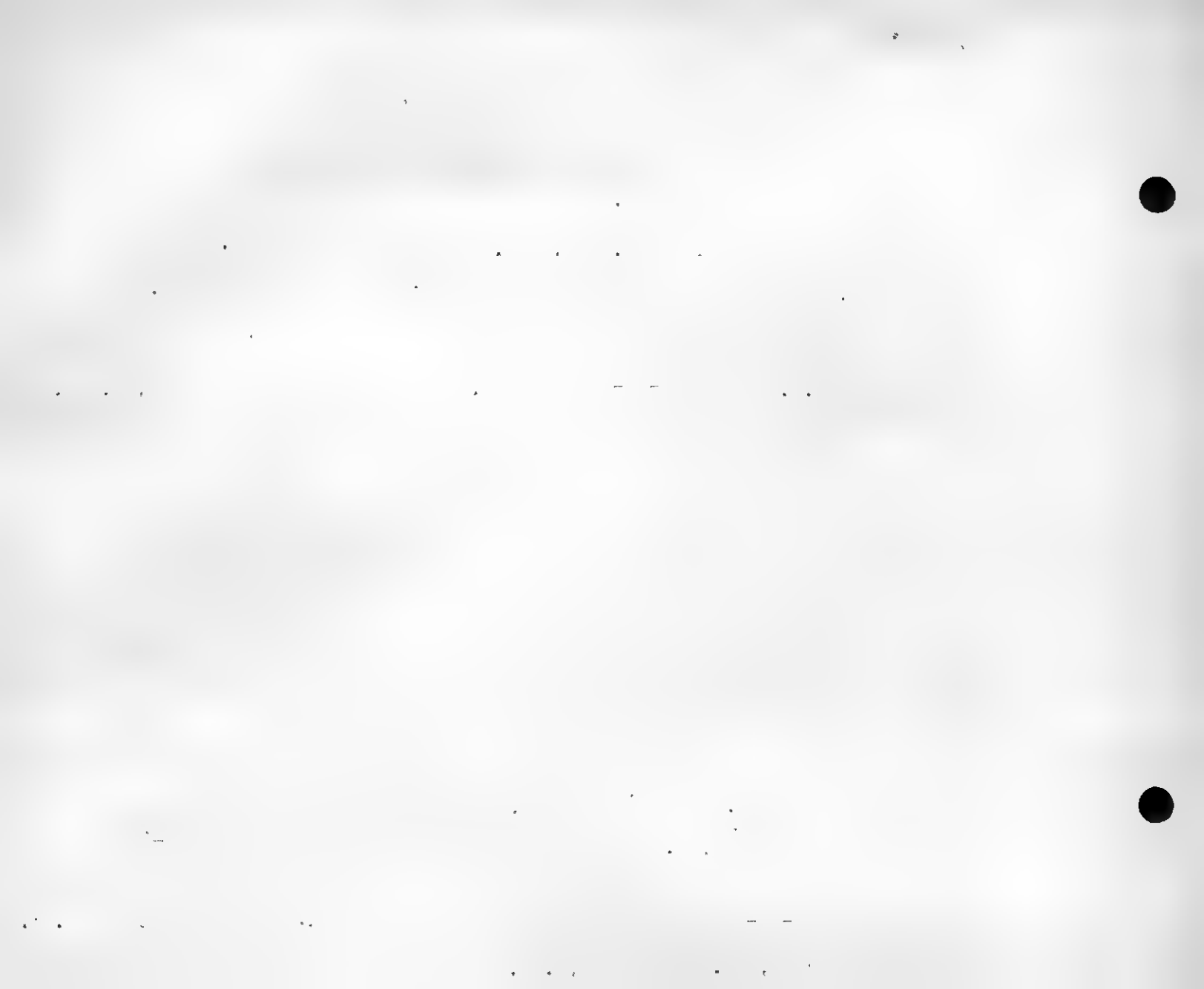


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Step 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08799										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08794																											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																															
1 DECEASED-NAME (Type or Print)			First			Middle			Last			2a DATE KNOWN OF EST- DEATH MATED <input checked="" type="checkbox"/> 6			Month			Day			Year			2b HOUR																							
Oscar									Enos Jr.															1969			unknown																				
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last, birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		IF UNDER 24 HRS HOURS		IF UNDER 24 HRS MIN.		2c DATE PRONOUNCED DEAD			Month			Day			Year			2d HOUR																			
M		W		17 Mar 1923		46 YRS.										6			26			19			69			9:40 P M																			
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																																			
Maryland				U.S.								Prince George Md																																			
10 CITY OR TOWN OF DEATH						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b KIND OF BUSINESS OR INDUSTRY																													
Landover						3109 75th. Ave. Apt. 10						Electrical engineer						Safeway																													
13a USUAL RESIDENCE (Where deceased admission) STATE						13b COUNTY						13c CITY OR TOWN						13d INSIDE CITY LIMITS?						13e STREET AND NUMBER																							
Md.						Prince George						Hyattsville						<input checked="" type="checkbox"/> NO <input type="checkbox"/>						3109 75th Ave.																							
14. FATHER'S NAME						First						Middle						Last						15 MOTHER'S MAIDEN NAME						First						Middle						Last					
Charles						Oscar						Enos												Ida						Lee						Crane											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO						17. INFORMANT												ADDRESS																							
Yes						W.W.II						235-28-3468												Mrs. Marie Compton Martinsburg, W. Va.																							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
																		Days																													
																		Over 1 yr																													
19a DATE OF OPERATION						19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?																																			
												<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																																			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No City or Town County State																																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		22b DATE SIGNED																													
ACTUAL SIGNATURE EXAMINER'S NAME (Type)						John Kehoe, M.D., Riverdale						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)						3-27-69																													
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b DATE						23c NAME OF CEMETERY OR CREMATORY						23d LOCATION (City or Town) (County) (State)																													
Burial						6-29-69						Rosedale Cemetery						Martinsburg Berkeley W. Va.																													
24. FUNERAL DIRECTOR						ADDRESS						25a REC'D BY REGISTRAR						25b REGISTRAR'S SIGNATURE																													
Brown Funeral Home, Inc. Martinsburg, W. Va.												JUN 30 1969						Charles J. J. J.																													



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and on any event within 72 hours after death.

08800		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08795	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 6-8-69 12:30am M	
Lloyd Dixon Evans							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD	2d HOUR
Male	White	1-7-1926	43 YRS			6 Month 8 Day 69 Year 11 00am	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Ohio		U. S. A.				Prince George's Md.	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Adelphi			9326 Lynnont Drive			Supertendent Construction	
13a USUAL RESIDENCE (Where deceased lived, if in institution on residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
Maryland			Prince George's		Adelphi		9326 Lynnont Drive
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
John H. Evans							Gertrude E. Dixon
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT		
Yes			WW 11		297 18 9652 Joan J. Evans Same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY.							
IMMEDIATE CAUSE (a) <u>Liver failure</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Cirrhosis of liver</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
				HOJR A M P M 19			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				22b DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				6-9-69			
23a BURIAL CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial				6/11/69		Baltimore National	
24 FUNERAL DIRECTOR				ADDRESS		23d LOCATION (City or Town) (County) (State)	
Francis Gasch's Sons				Hyattsville, Md.		Baltimore Baltimore Md.	
25a RECD BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
DATE JUN 17 1969				J. Kehoe			

08801

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08797

Item 3 Film 44 7/1/69 kk

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) CLYDE M FARMER			2a DATE OF DEATH JUNE Month 18 Day 69 Year		2b HOUR A 1102 M
3 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH 5 OCT 1905		6 AGE (In years last birthday) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) NORTH CAROLINA	7b CIT. ZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGE Md	
10 CITY OR TOWN OF DEATH ANDREWS AFB	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAFHOSP	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NURSE		12b KIND OF BUSINESS OR INDUSTRY HOSPITAL	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE NORTH CAROLINA		13b CITY OR TOWN WILSON	13c INSIDE CITY LHM 75? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 603 WHITEHEAD AVE	
14 FATHER'S NAME First Middle Last EDWIN G FARMER		15 MOTHER'S MAIDEN NAME First Middle Last Unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO 241323026	17 INFORMANT BILLIE G FARMER		
		7210 SOUTH HILDRETH AVE TUCSON ARIZONA			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest 4412 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Haemorrhage 2° T. Bleeding diathesis DUE TO, OR AS A CONSEQUENCE OF (c) Rupture of abdm. aortic aneurysm DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)	
21d INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State	
22a I certify that (X) (this hospital) attended the deceased from 11 Jun , 19 69 , to 18 Jun , 19 69 , that (X) (we) last saw the deceased alive on 18 Jun , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death					
22b SIGNATURE Frank A. Camp		DEGREE MD		22c DATE SIGNED 18 Jun 69	
22d PHYSICIAN'S NAME (Type) FRANK A CAMP LCOL USAF MC		22e ADDRESS MALCOLM GROW USAFHOSP ANDREWS AFB			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 6-22-69	23c NAME OF CEMETERY OR CREMATORY Wesleywood Cem.		23d LOCATION (City or Town) (County) (State) Wilson North Carolina	
24 FUNERAL DIRECTOR W. W. Chambers Co. 517-11th St. S.E.		25a REC'D BY REGISTRAR JUN 23 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4837

08802		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		08798	
1 DECEASED NAME (Type or print)		First		Middle		Last	
Ralph				Fedder			
3 SEX		4 RACE		5 DATE OF BIRTH		20. DATE OF DEATH	
Male		White		11-08-07		Month 4, Day 1969	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6 AGE (In years last birthday) 64 61 YRS	
unknown		unknown				9. COUNTY OF DEATH Prince George's Md.	
1d CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George's Gen. Hosp.					
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13e STREET AND NUMBER	
MD		Prince George's Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		5612 Chillum Hgts. Drive	
14 FATHER'S NAME		First		Middle		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) Etiology undetermined							
DUE TO, OR AS A CONSEQUENCE OF							
(c) Focal Broncho-pneumonia							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (this hospital) attended the deceased from May 28, 1969, to June 4, 1969, that (we) lost saw the deceased alive on June 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-4-69	
22a PHYSICIAN'S NAME (Type)		Luis Bentolila, M.D.		22e. ADDRESS Prince George's General Hospital			
23a B. RIAL CREMATION REMOVAL (Specify)		23b DATE 6-16-69		23c NAME OF CEMETERY OR CREMATORY Md. Med. School		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR JUN 18 1969		25b REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

08803

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08799

1 DECEASED NAME (Type or print) <u>Louis</u> First Middle Last <u>Feitel</u>			2a DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>69</u>			2b HOUR <u>6:00</u> M	
3 SEX <u>male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>9-1-94</u>		6 AGE (In years last birthday) <u>74</u> YRS.	
7a BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		COUNTY OF DEATH <u>Prince Georges</u> Md.	
10 CITY OR TOWN OF DEATH <u>Adelphi</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Major Care N. York</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>ICE CREAM DIST. - RET.</u>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <u>MARYLAND</u>		13b COUNTY <u>MONTGOMERY</u>		13c CITY OR TOWN <u>SILVER SPR.</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <u>HERMAN</u> <u>FEITEL</u>		15 MOTHER'S MAIDEN NAME First Middle Last <u>SARAH</u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>YES</u> (If yes give year or dates of service) <u>WW I</u>		16b SOCIAL SECURITY NO <u>136-05-6299</u>		17 INFORMANT <u>SON</u>		Address <u>DR. MORRIS FEITEL - 4 CREST PARK CT. S.S. Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary</u> <u>4x4x</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CIRCA 1 WEEK</u> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PARKINSON'S DISEASE</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory) OFFICE, BUILDING, ETC		21f LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 19 68</u> to <u>6/25, 19 69</u> , that (I) (we) last saw the deceased alive on <u>6/25 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Lawrence D. Marcus MD</u> DEGREE <u>MD</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c DATE SIGNED <u>6/25/69</u>			
22d PHYSICIAN'S NAME (Type) <u>LAWRENCE D. MARCUS</u>				22e ADDRESS <u>1111 SPRING ST. SILVER SPR. Md.</u>			
23a B. RIAL, CREMAT. ON, REMOVAL (Specify) <u>BURIAL</u>		23b DATE <u>6-27-69</u>		23c NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEM.</u>		23d LOCATION (City or Town) (County) (State) <u>ISELIN NEW JERSEY</u>	
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS - WASH. DC</u>				25a REC'D BY REGISTRAR <u>JUN 30 1969</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08800

VR A15ME (5)
10M REV 1-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, sign, date, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item #23a,b,c,d. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 24 Film 413 6/25/69 kk										08801	
1 DECEASED NAME (Type or print) First Middle Last Mary Fletcher						2a DATE OF DEATH Month Day Year June 13 69			2b HOUR 7:45p M		
3 SEX female		4 RACE colored		5. DATE OF BIRTH March 21, 1939		6 AGE (In years last birthday) 30 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country) D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) NA			12b KIND OF BUSINESS OR INDUSTRY NA		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b COUNTY Prince George Seat Pleasant		13c CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 7286 Colb Street	
14 FATHER'S NAME First Middle Last WILLIAM EDWARD FLETCHER						15 MOTHER'S MAIDEN NAME First Middle Last FRANCES C. PIRECE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NA				16b SOCIAL SECURITY NO NA		17 INFORMANT Address MARTINA COLEMAN, 9933 Franklin St., Lanham MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 4 DUE TO, OR AS A CONSEQUENCE OF Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 7, 1969 to June 13, 1969 , that (I) (we) last saw the deceased alive on June 13, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death											
22b SIGNATURE Arthur W. Hefsky						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 16 June 69		
22d. PHYSICIAN'S NAME (Type) Arthur W. Hefsky						22e. ADDRESS 1015 Spring St.					
23a BURIAL, CREMATION, OR REMOVAL (Specify)			23b DATE June 17, 1969			23c NAME OF CEMETERY OR CREMATORY Harmony Mem. Park			23d LOCATION (City or Town) (County) (State) Highland Park, Maryland		
24. FUNERAL DIRECTOR 4925 Dean Ave. NE ADDRESS H.S. Washington & Sons Washington, D.C.						25a REC'D BY REGISTRAR JUN 19 1969			25b REGISTRAR'S SIGNATURE Charles Judge		

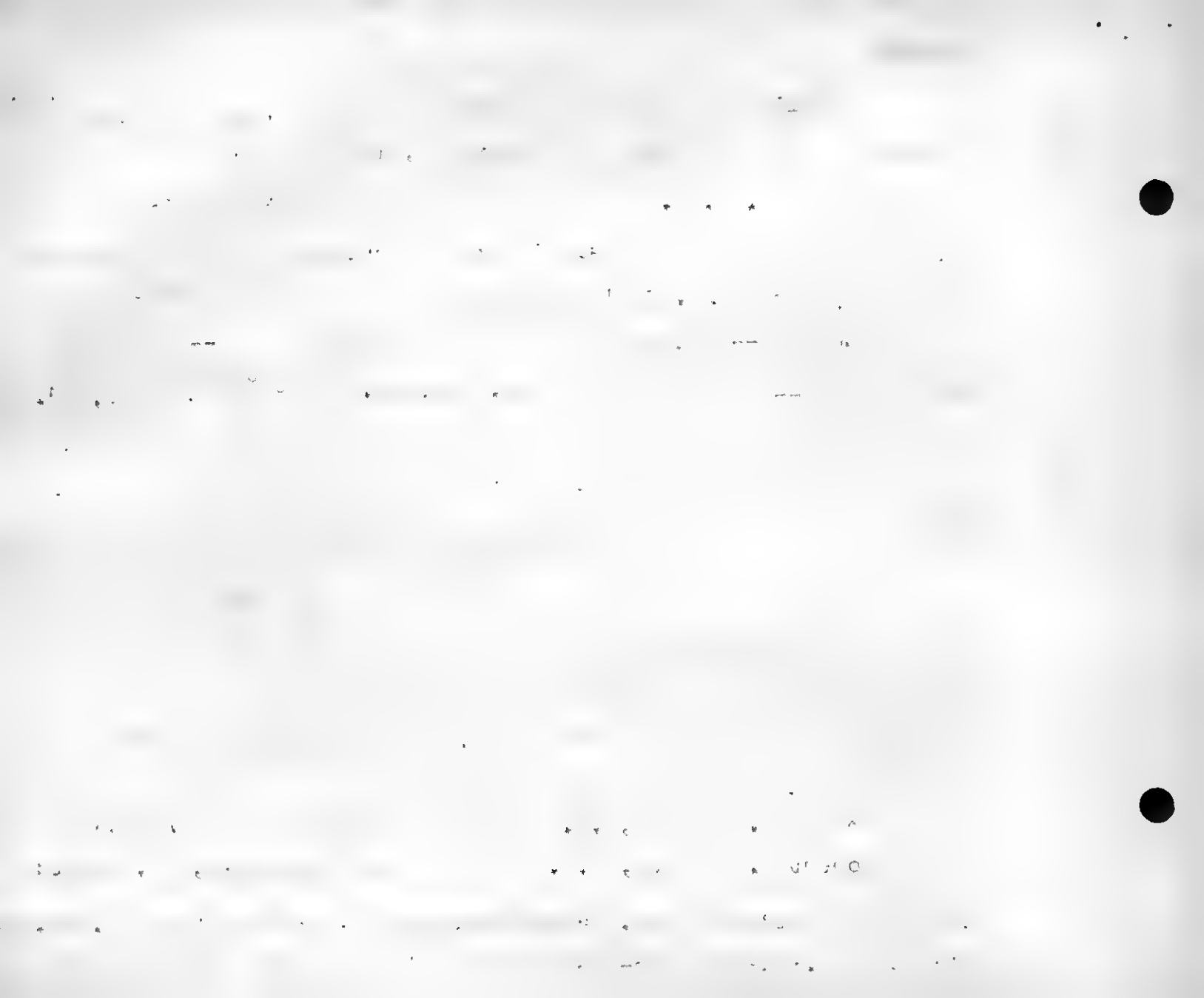
08806

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Lillie Lee Ford			2a. DATE OF DEATH Month June Day 9 Year 1969			2b. HOUR 5:30 MIN M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 6, 1892		6. AGE (In years last birthday) 77 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges	
10. CITY OR TOWN OF DEATH Upper Marlboro		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Main Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Lee Middle -- Last Howard		15. MOTHER'S MAIDEN NAME First Agnes Middle -- Last Walton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. --		17. INFORMANT Mrs. Olive E. Dyck-Camp 6018 Birch Lane Spring Springs, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CV Disease DUE TO, OR AS A CONSEQUENCE OF (c) 15 yrs							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 47 , to 9 June , 19 69 , that (I) (we) last saw the deceased alive on 9 June , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert B. Sasscer, M.D.				22c. DATE SIGNED 6/9/69:			
22d. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M.D.				22e. ADDRESS Upper Marlboro, Md. 20870:			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/12/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City or Town) (County) (State) Upper Marlboro Pr. Geo. Md	
24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Funeral Home-Maryland:				25a. REC'D BY REGISTRAR DATE JUN 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL CLINIC: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08807										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08803																			
Item 6 Film 413 6/19/69 kk										CERTIFICATE OF DEATH																													
1. DECEASED NAME (Type or print)					First John					Middle R.					Last Forney					2a. DATE OF DEATH					2b. HOUR														
															Month 6					Day 8					Year 69					2:40 PM									
3 SEX Male					4. RACE White					5 DATE OF BIRTH 01-13-00					6. AGE (in years last birthday) 69 YRS.					F UNDER 1 YEAR MONTHS					IF UNDER 24 HRS DAYS					HOURS					MIN				
7a. BIRTHPLACE (State or foreign country) DC.					7b. CITIZEN OF WHAT COUNTRY? USA					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH Prince Georges County Md.																								
10 CITY OR TOWN OF DEATH Cheverly					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp					12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) PLUMBER					12b KIND OF BUSINESS OR INDUSTRY																								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland					13b COUNTY Prince Georges					13c CITY OR TOWN Hyattsville					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER 8000 Burnside Road																			
14 FATHER'S NAME First John					Middle R.					Last Forney					15 MOTHER'S MAIDEN NAME First Elizabeth					Middle Seek					Last														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown N					16b SOCIAL SECURITY NO 925103419					17 INFORMANT Mr John P Forney					Address 5803 RUTHER ST. BETHESDA, MD																								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMABARCOMA RIGHT ILIUM										2 MOS																													
1706																																							
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last																																							
DUE TO, OR AS A CONSEQUENCE OF (b)																																							
DUE TO, OR AS A CONSEQUENCE OF (c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
ARTERIOSCLEROTIC HEART DISEASE																																							
19a DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC					21f LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from FEB 1, 1969, to JUNE 8, 1969, that (I) (we) lost saw the deceased alive on JUNE 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE Samuel J. N. Sugar										22c. DATE SIGNED June 8 '69					22d. PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR					22e ADDRESS 4637 EASTERN AVE WASHINGTON DC 20018																			
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE 11 JUNE 1969					23c NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL					23d LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND																								
24. FUNERAL DIRECTOR W.W. CHAMBERS					ADDRESS B. RIVERDALE, MARYLAND					25a REC'D BY REGISTRAR JUN 16 1969					25b. REGISTRAR'S SIGNATURE [Signature]																								

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiners Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08808										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08804																																							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																																											
1 DECEASED NAME (Type or Print)										First Middle Last										2a DATE KNOWN OF DEATH										Month Day Year										2b HOUR																			
Leonard Joseph Fox																				6-23-69										19 2:32pm																													
3 SEX										4 RACE										5 DATE OF BIRTH										6 AGE (In years last birthday)										7c DATE PRONOUNCED DEAD										2d HOUR									
Male										White										2-10-1899										70 YRS										6 23 69 19 2:46pm																			
7a 8 RTHPLACE (State or foreign country)										7b CIT ZEN OF WHAT COUNTRY?										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH										Md.																			
IOWA										USAMERICA																				Prince George's																													
10. CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																													
Cheverly										Prince George Hospital										ENGINEER										D.C. GEN'T.																													
13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE										13b. COUNTY										13c CITY OR TOWN										13d INSIDE CITY LIMITS?										13e STREET AND NUMBER																			
Maryland										Prince George's Mt. Rainier										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										4108 29th. Street																													
14. FATHER'S NAME										First Middle Last										15 MOTHER'S MAIDEN NAME										First Middle Last																													
JOHN										MARTIN FOX										MARTHA										SARAH STALLMAN																													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										(If yes give war or dates of service)										16b SOCIAL SECURITY NO										17 INFORMANT										ADDRESS																			
No																				215-14-7444										RICHARD L. FOX										5413 CARTER'S LANE RIVERDALE MD 20840																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART 1 DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
										IMMEDIATE CAUSE (a) Heart failure										minutes																																							
										DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										over 2 yrs.																																							
										(b)																																																	
										DUE TO, OR AS A CONSEQUENCE OF																																																	
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY?										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b TIME OF INJURY Month, Day, Year										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
										P.M. 19																																																	
21d INJURY OCCURRED										21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f LOCATION Street or R.F.D. No										City or Town										County										State									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																																																											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:										Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																	
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED																																							
										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										6-24-69																																							
EXAMINER'S NAME (Type)										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										ADDRESS (Street, city, town, or county)																																							
John Kehoe MD										Riverdale, Md.																																																	
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town) (County) (State)																													
BURIAL										JUNE 26, 1969										FORT LINCOLN CEM.										COLMAR MANOR PRINCE GEORGES MD.																													
24 FUNERAL DIRECTOR										ADDRESS										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE																													
WW CHAMBERS Co.										RIVERDALE MD.										DATE 30 1969										Charles Judgen																													

7769

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Baby			Girl		Friend	June 4 1969			11:45 A	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		June 4, 1969		YRS.		6 07		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
USA						Prince George's Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MD			Prince George's		Hillside		YES <input type="checkbox"/> NO <input type="checkbox"/>		111 59th Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 7769 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atelectosis of lungs</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
2 d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) XXXX XXXXX attended the deceased from June 4, 1969, to June 4, 1969, that (I) XXXX saw the deceased alive on June 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>David Anders</u> M.D. DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/6/69			
22d. PHYSICIAN'S NAME (Type)					22e ADDRESS 3308 Dodge Park Rd Landover Md					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Cremation		6-14-69		Pr. George's Gen. Hospital		Cheverly, Pr. George's, Maryland				
24 FUNERAL DIRECTOR					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Harry W. Penn, Jr., Administrator					JUN 10 1969		[Signature]			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item #8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
CONNIE			WILLIAMSON			GAMBLE			6:30 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
F	W	7-11-1917	78 YRS	MONTHS DAYS		HOURS MIN		Month Day Year		6:00 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md.	
N. CAROLINA		USA		WIDOWED		DIVORCED		PRINCE GEORGES Ct.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
UPPER MARLBORO			ANDREWS A.F.B. HOSP.			HOUSEWIFE			AT HOME		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER		
N. CAROLINA			MECKLENBURG			DAVIDSON			CONCORD AVE		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
THOMAS SQUIRES WILLIAMSON JR.			LUBRICATOR			LONG					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
NO			Unknown			JOSEPH G. GAMBLE			13512 CARROLL CT. UPPER MARLBORO MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HT FAILURE</u>										MIN	
4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD</u>										5 yrs	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Diabetes Mellitus - 15 yrs</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			6-29-69		
JOHN KENOE M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			7-3-69			Williamson Chapel Co. - Charlotte, North Carolina					
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
W.W. CHAMBERS - 517-11 TH ST. S.E. WASH, D.C.						JUL 7 1969			Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08811

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08807

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 6-2-69 19 12:10am		2b. HOUR
Nancie		F	Geiss				
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS MONTHS DAYS HOURS MIN.	2c DATE PRONOUNCED DEAD Month 6 Day 2 Year 69 12:50am		2d HOUR
Female	White	5-5-1928	41 YRS				
7a BIRTHPLACE (State or foreign country) Texas		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md	
10 CITY OR TOWN OF DEATH Clinton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Clinton Medical Center		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Clinton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last Arch L Foster		15 MOTHER'S MAIDEN NAME First Middle Last Mary W Stanley		13e STREET AND NUMBER 7507 Hastings Drive			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT ADDRESS Werdna Cochran 4313 Ogden Dr Fremont Calif			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gun shot wounds of chest DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 12-10am 6-2-69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Under Police Investigation			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No. City or Town County State same as #13			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 6-3-69	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 6-7-1969		23c NAME OF CEMETERY OR CREMATORY Haskell Cemetery		23d LOCATION (City or Town) (County) (State) Haskell Texas	
24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland				25a REC'D BY REGISTRAR DATE JUN 10 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08812					08808				
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) DEREK MIDDLE ZELAND LAST GLADSTONE					2a. DATE OF DEATH JUN Month 3 Day 69 Year			2b. HOUR P 5:50M	
3 SEX Male		4. RACE Caucasian		5 DATE OF BIRTH 31 May 69		6 AGE (In years last birthday) YRS		IF UNDER 1 YEAR MONTHS 3 DAYS 3	
7a BIRTHPLACE (State or foreign country) Md		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGE			
10 CITY OR TOWN OF DEATH ANDREWS AFB		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital state location) MALCOLM GROW USAF HOSP		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NA		12b KIND OF BUSINESS OR INDUSTRY NA			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b COUNTY Ma		13c CITY OR TOWN Hillcrest		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 3364 Curtis Dr.	
14. FATHER'S NAME First KENNETH Middle M Last GLADSTONE					15. MOTHER'S MAIDEN NAME First ESTA Middle R Last BLUMENTHAL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> NO or unknown		16b SOCIAL SECURITY NO NA		17 INFORMANT Address FATHER NAV COMM STA WASH D.C.					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory arrest 55 1.5 DUE TO, OR AS A CONSEQUENCE OF (b) Diaphragmatic hernia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 31 May 69		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED Diaphragmatic hernia			20a AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town		County State	
22a I certify that he (this hospital) attended the deceased from 31 May , 19 69 , to 3 Jun , 19 69 , that he (we) last saw the deceased alive on 3 Jun , 19 69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) did (did not) view the body after death.									
22b SIGNATURE Paul H Penzer MD					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 3 Jun 69		
22d PHYSICIAN'S NAME PAUL H PENZER CAPT USAF MC					22e ADDRESS MALCOLM GROW USAF HOSP ANDREWS AFB				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 6/6/69		23c NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		23d LOCATION (City or Town) (County) (State) Arlington, Va.			
24. FUNERAL DIRECTOR Bernard Danzansky & Son				ADDRESS 3501 14th St Wash. D.C.		RECORDED BY REG STRAR JUN 9 1969		25b REGISTRAR'S SIGNATURE John J. Judge	

08813

CERTIFICATE OF DEATH

08809

1 DECEASED NAME (Type or print) BERNARD			First Middle Last Goldstein			2a. DATE OF DEATH Month 6 Day 12 Year 69			2b. HOUR 2:15 A M								
3 SEX male			4 RACE W			5. DATE OF BIRTH 6-14-79			6. AGE (in years last birthday) 89 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Roumania			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Prince George's Md								
10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) SELF EMPLOYED			12b. KIND OF BUSINESS OR INDUSTRY GROCERY								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.			13b. COUNTY Washington			13c. CITY OR TOWN Washington			13d. INSIDE CITY, Y.N. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1223 Missouri Ave. N.W.					
14 FATHER'S NAME First Middle Last - UNKNOWN			15. MOTHER'S MAIDEN NAME First Middle Last - UNKNOWN														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <input checked="" type="checkbox"/> UNKNOWN (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 577-48-1139			17 INFORMANT HARRY Goldstein			Address 7 Sussex Rd. Silver Spring, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 4120 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) terminal Pulmonary Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one month					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Jan , 1967, to 6-12 , 1969, that (I) (we) last saw the deceased alive on May 29 , 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Charles S. Sahakian			DEGREE MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 6-12-69								
22d. PHYSICIAN'S NAME (Type) CHARLES S. SAHAKIAN			22e. ADDRESS 601 Landown Rd			22f. CITY, STATE AND ZIP Chesapeake, D.C.											
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL			23b. DATE 6-13-69			23c. NAME OF CEMETERY OR CREMATORY OTTEV. SHILOH CEM			23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.								
24. FUNERAL DIRECTOR CHARLES FUNERAL HOME			ADDRESS 4219 7th St NW			25a. REC'D BY REGISTRAR JUN 16 1969			25b. REGISTRAR'S SIGNATURE Charles Judge								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 4 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08814		CERTIFICATE OF DEATH						08810			
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b. HOUR		
Joanna			NMI			Goliheh			6 22 69 10:30		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		7 UNDER 1 YEAR		
Female		white		03-19-12			57 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			
Maryland			USA					Prince George's County Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.			Housewife			At Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.			Prince George's		Forestville		YES <input type="checkbox"/> NO <input type="checkbox"/>		7679 Walters Lane		
14 FATHER'S NAME First Middle Last			15 MOTHER'S M A DEN NAME First Middle Last								
Sencie Seaborn			Margaret			Cage					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT			Address			
No			None		Basil E. Goliheh			Same as #13			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of ovary</u> 1830 DUE TO, OR AS A CONSEQUENCE OF <u>with distant Metastasis.</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <u>And social nutrition.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>May 16</u> , 19 <u>69</u> , to <u>June 22</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 22</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6-22-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Dr. Nair</u>						22e. ADDRESS <u>Prince George's General Hospital</u>					
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6/25/69		Fort Lincoln Cemetery		Colmar Manor Maryland					
24. FUNERAL DIRECTOR ADDRESS <u>J. Wm. Lees Sons, Co., Washington, D.C.</u>						25a. RECEIVED BY REGISTRAR DATE <u>JUN 26 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

4400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08815									
08811									
1 DECEASED-NAME (Type or print) First Middle Last Homer William Golliday						2a DATE OF DEATH Month Day Year June 28 1969		2b HOUR 9 P.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 07/21/81		6 AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Va		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md			
10 CITY OR TOWN OF DEATH Cheverly, Maryland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) P.G. General Hospital		12a USUAL OCCUPATION (Kind at work done during most of working life, even if retired) Carpenter		12b KIND OF BUSINESS OR INDUSTRY self			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Prince G.		13c CITY OR TOWN Suitland		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 5501 Darel Dr	
14 FATHER'S NAME First Middle Last James Golliday				15. MOTHER'S MAIDEN NAME First Middle Last Anna Clevenger					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		(If yes give war or dates of service)		16b SOCIAL SECURITY NO. 224-10-8898A		17 INFORMANT P.G. General Hospital		Address Cheverly, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism, multiple</u> 295.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infarct right temporal lobe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral artery stenosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hrs, 1 mo, 2 yrs.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (H) (this hospital) attended the deceased from 5/26, 1969, to 6/28, 1969, that (H) (we) last saw the deceased alive on 6/28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death									
22b SIGNATURE Norman Dowd		DEGREE M.D.		22c DATE SIGNED 6/29/69		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
22d PHYSICIAN'S NAME (Type) Norman Dowd		22e ADDRESS 3503 Penny St. (Hindman)							
23a BURIAL, CREMATION, REMOVAL (Specify) Removal		23b DATE 6-29-69		23c NAME OF CEMETERY OR CREMATORY Macedonia Cemetery		23d LOCATION (City or Town) (County) (State) Winchester Va.			
24 FUNERAL DIRECTOR F. Gasch		ADDRESS 4739 Balt Ave Hyattsville Md.		25a FILED BY REGISTRAR JUL 7 1969		25b REGISTRAR'S SIGNATURE John Carlos Judge			



4319

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A+S (4)
4SM 1/69

08816		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08812	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
Caesar I. Gomes						June 17, 1969 7:20A M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	
Male		White		02-03-98		71 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
British Guiana		U. S. A.				Prince George's Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George's Gen. Hosp		Ret. Machinist			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. HOUSE CITY LOT?	
MD		Prince George's		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	
First Middle Last		First Middle Last		Yes No		Address	
Jose Gomes		Anna Gousalves		Yes		WW 1	
				578 36 1513		Catherine A Gomes Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Damage</u> 4319 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>same</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 yrs</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		21g. CITY OR TOWN			
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/16, 1969</u> to <u>6/17, 1969</u> , that (I) (we) saw the deceased alive on <u>6/16, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				22c. DATE SIGNED <u>6/17/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>F.E. MESSER MD</u>				22e. ADDRESS <u>441078</u>			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		6/20/69		Gate of Heaven		Silver Spring Montg. Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE	
Francis Gasch's Sons Hyattsville, Md.				JUN 20 1969		<u>[Signature]</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08817

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08813

1 DECEASED NAME (Type or Print) KATHLEEN ANNE GREEN		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month June Day 20 Year 1969		2b HOUR 12:45
3 SEX F	4 RACE W	5 DATE OF BIRTH May 26 1966	6 AGE (n years last birthday) 3 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0
7a BIRTHPLACE (State or foreign country) Washington Dc		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince Georges
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General	12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Child	12b KIND OF BUSINESS OR INDUSTRY ---
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b COUNTY Prince Georges	13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d STREET AND NUMBER 2803 Federal Lane
14 FATHER'S NAME First Calvin Middle green Last green		15 MOTHER'S MAIDEN NAME First Mary Middle Frawley Last ---		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO ---	17 INFORMANT Calvin Green ADDRESS 2803 Federal Lane Bowie Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Wounds multiple				inst
DUE TO, OR AS A CONSEQUENCE OF (b) and severe				
DUE TO, OR AS A CONSEQUENCE OF (c) Hit by a car				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION no		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH no		21b. TIME OF INJURY Month, Day, Year June 20 1969 HOLR A.M. no P.M. ---		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Subject hit by a car
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION (Street or R.F.D. No) Federal Lane and Fern St City or Town Bowie County Prince Georges State Md
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Dayton O Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6-20-69
EXAMINER'S NAME (Type) DAYTON O WATKINS		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) ---
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JUNE 23, 1969	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART Cem	23d. LOCATION (City or Town) Bowie (County) P.G. (State) Md.	
24. FUNERAL DIRECTOR Robert H. Smith		25a. REC'D BY REG STRAR ---		25b. REGISTRAR'S SIGNATURE Charles Judge
24. FUNERAL HOME LANHAM FUNERAL HOME, Lanham Md.		DATE JUN 23 1969		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08818

CERTIFICATE OF DEATH

10306

1. DECEASED-NAME (Type or print) Hall Baby Roy			2a. DATE OF DEATH Month June Day 27 Year 1969			2b. HOUR 11:50p M					
3 SEX male		4 RACE white		5. DATE OF BIRTH June 26, 1969		6. AGE (in years last birthday) nb YRS.		IF UNDER 1 YEAR MONTHS 1 DAYS 1			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? 2602		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY 1		13c CITY OR TOWN Blyd Hets		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5210 Clark Place		
14 FATHER'S NAME First Middle Last Billy E. Hall			15. MOTHER'S MAIDEN NAME First Middle Last Barbara Morningstar								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Immaturity DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Prematurity DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from June 26 , 19 69 , to June 27 , 19 69 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Leon D. Dufault						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/27/69	
22d. PHYSICIAN'S NAME (Type) Leon D. Dufault						22e. ADDRESS 6011...					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 7-11-69			23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hosp.			23d. LOCATION (City or Town) (County) (State) Cheverly PG Md.		
24 FUNERAL DIRECTOR Harry W. Penn						ADDRESS ...		25a. REC'D BY REGISTRAR JUL 15 1969		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08819 Item #6, Film 4114 7/7/69 km		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08814	
1 DECEASED NAME (Type or print) First Middle Last Theodore John Hammer					2a. DATE OF DEATH Month Day Year 06 24 69		2b. HOUR 10:25 PM
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 10-31-87		6. AGE (In years last b. day) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges County, Md	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) STATIONARY ENGINEER (R)		12b. KIND OF BUSINESS OR INDUSTRY FIREMAN	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN New Carrollton		13d. STREET AND NUMBER 7603 Fontainebleau Dr.	
14. FATHER'S NAME First Middle Last Theodore John Hammer Sr.				15. MOTHER'S MAIDEN NAME First Middle Last Cecelia McCue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16b. SOCIAL SECURITY NO. 215-52-6728		17. INFORMANT Mrs. Irene J. Hammer		Address 3800 40 Stm 13C	
18. CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure.</u> DUE TO, OR AS A CONSEQUENCE OF <u>Chronic ischemic heart disease.</u> DUE TO, OR AS A CONSEQUENCE OF <u>General atherosclerosis.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19, 1969</u> to <u>June 24, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 24, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>L.W. Malin</u>				22c. DATE SIGNED 6/25/69			
22d. PHYSICIAN'S NAME (Type) L.W. MALIN MD				22e. ADDRESS Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE June 27, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland P.G.'s Md.	
24. FUNERAL DIRECTOR Robert N. Bull				25a. REC'D BY REGISTRAR JUN 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

08820

CERTIFICATE OF DEATH

10309

1. DECEASED NAME (Type or print) Hanlein Baby Girl			2a. DATE OF DEATH June Month 27 Day 1969			2b. HOUR 7:50 PM			
3 SEX female		4 RACE white		5 DATE OF BIRTH June 27, 1969		6 AGE (In years lost birthday) 11 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			
10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased admission) STATE Md.		13b COUNTRY Prince George's Laurel		13c CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME Joseph Hanlein		15 MOTHER'S M.A.DEN NAME Ann C Bell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT Address					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATE ON

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1969</u> , to <u>June 27, 1969</u> , that (I) (we) lost saw the deceased alive on <u>June 27</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Gordon Kelley</i> MD				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 27, 1969	
22d. PHYSICIAN'S NAME (Type) Gordon Kelley				22e. ADDRESS Hyattsville, Md.			

23a BURIAL, CREMATION REMOVAL (Specify)		23b. DATE 7-11-69		23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly PG Md	
24. FUNERAL DIRECTOR <i>Kerry W. Dunn, Jr., Adm.</i>		ADDRESS		25a. REC'D BY REGISTRAR JUL 15 1969		25b. REGISTRAR'S SIGNATURE <i>Kerry W. Dunn, Jr.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

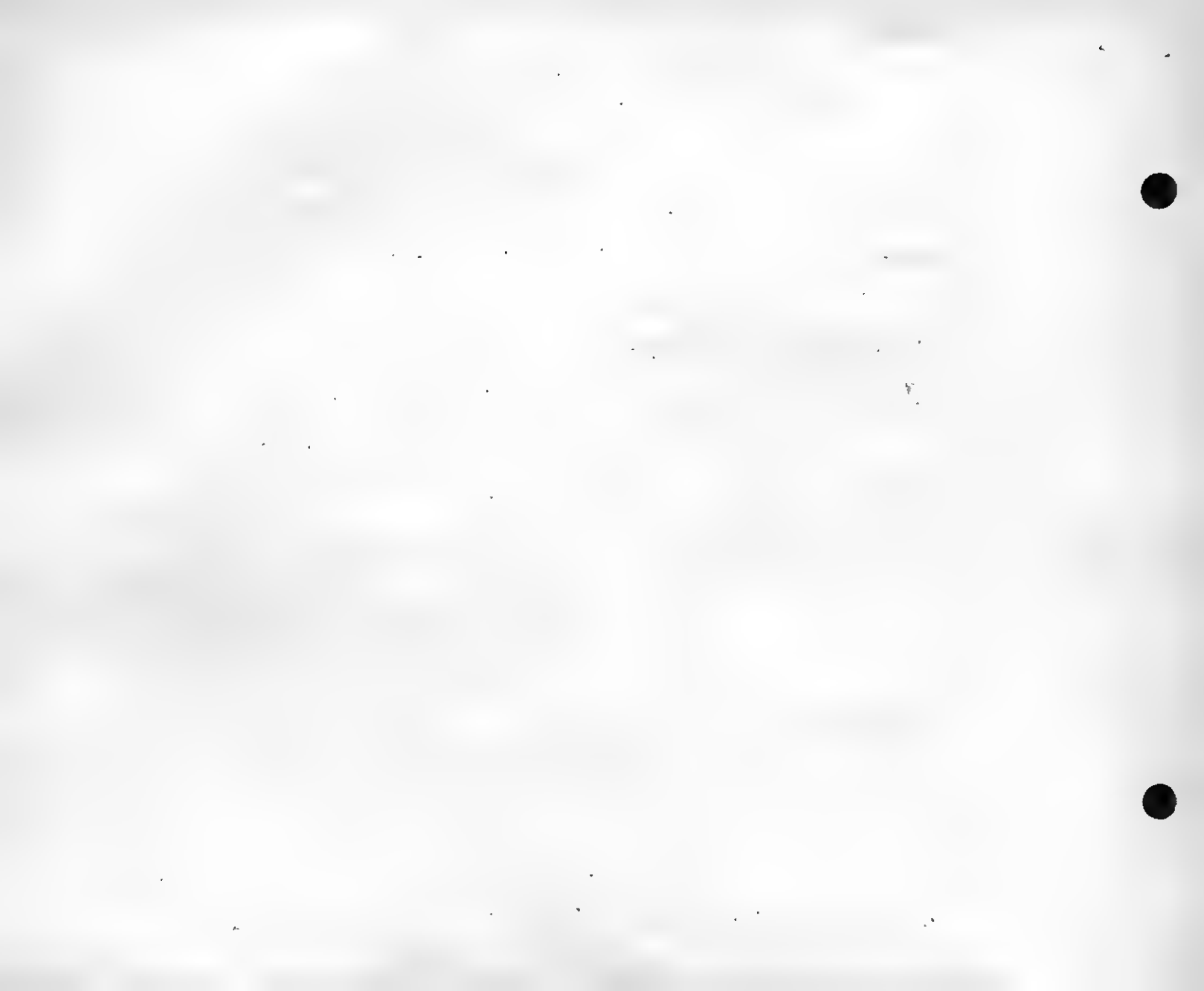
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First		Middle		Last		2c. DATE OF DEATH Month Day Year		
Ephraim					Harrid				June 3 1969		
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Colored		--- Oct. ?			99 YRS.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland			U.S.A.					Prince George's Md			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.			Labor					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY & HILLS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			Prince George's			Carmody Hills				406 Carmody Hills Drive	
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Thomas					Harrid				Grace Diggs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT			
								Hazel Thomas 4902 Lakeland R.d. College Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebrovascular accident											
4369 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic vascular disease											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No			City or Town		State
22a. I certify that (X) (this hospital) attended the deceased from May 13, 1969, to June 3, 1969, that (X) (we) lost saw the deceased alive on June 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Luis Bentolila, M.D.						Prince George's General Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)	(State)
			5-7-69		Brown's Ch. Cem.			Port Republic, Cal.			Md.
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Pinkney E. Sewell						Prince Fred. Md			JUN 9 1969		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First Marjorie		Middle O.		Last HAUSWIRTH		2a. DATE OF DEATH Month Day Year June 16 1969		2b HOUR 9:15 AM
3 SEX Female	4 RACE White		5 DATE OF BIRTH 08-02-25			6 AGE (In years last birthday) 43 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		7 UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) MASS		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md				
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD		13b COUNTY Prince George's		13c CITY OR TOWN College Pk		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 9526 49th Ave		
14 FATHER'S NAME First Middle Last WINSTON CHAMBERLAIN		15 MOTHER'S MAIDEN NAME First Middle Last HILDA SADLER		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of serv.) NO				16b SOCIAL SECURITY NO 023-14-7072		17 INFORMANT Address JOHN J. HAUSWIRTH, Sr. #13
18 CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute peritonitis due to pelvic abscess</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>perforated acute gastric ulcers</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No		City or Town		County		State
22a I certify that (I) (this hospital) attended the deceased from <u>05-22</u> , 19 <u>67</u> , to <u>6-16</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Thomas Hernandez</u>		DEGREE Thomas Hernandez, M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 6/16/69
22d PHYSICIAN'S NAME (Type) Thomas Hernandez, M.D.		22e ADDRESS Prince George's Gen. Hosp.								
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 19 JUNE 1969		23c NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d LOCATION (City or Town) (County) (State) WASHINGTON, D.C.				
24 FUNERAL DIRECTOR W.W. CHAMBERS Co		ADDRESS RIVERDALE MD		25a REC'D BY REGISTRAR JUN 18 1969		25b REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

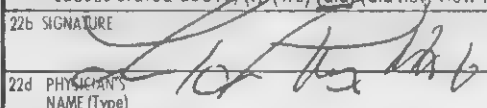
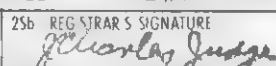
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08823				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08817			
1 DECEASED NAME (Type or print)				First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR	
JOHN ROLAND HAWKINS							Month	Day	Year	5:00 PM	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		7 IF UNDER 1 YEAR		
MALE		Colored		3-7-1898			71 YRS.		MONTHS 2 DAYS 29		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			10	
MARYLAND		U.S.A.					PRINCE GEORGE			MD	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
CLINTON			PINE VIEW GARDENS								
13a USUAL RESIDENCE (Where deceased lived if not in hospital admission) STATE				13b COUNTY		13c CITY OR TOWN		13d IS DE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland				Prince Georges		BOWIE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13125 11th St.	
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
XXXXX Richard Hawkins				Rachael Brandford							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (None or unknown) None				16b SOCIAL SECURITY NO		17 INFORMANT		Address			
				218 56 3101		Eileen J. Marcos		Same As Above			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>											
4124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary insufficiency</u>											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (c) <u>Cardiovascular atherosclerotic disease</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Decubitus & embolus</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f EDUCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>2-13, 1969</u> to <u>6-12, 1969</u> , that (I) (we) last saw the deceased alive on <u>6-12, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						22c DATE SIGNED					
<u>Alfred R. Lapin</u>											
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS					
<u>ALFRED R. LAPIN, MD</u>						<u>CLINTON, MD.</u>					
23a BURIAL, CREMATION, or other disposition (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
<u>Burial</u>		<u>6/14/69</u>		<u>Resurrection Cemetery</u>		<u>Clinton Pr. Geo. Md.</u>					
24 FUNERAL DIRECTOR ADDRESS						25a REG. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
<u>Francis Gasch's Sons Hyattsville, Maryland</u>						<u>JUN 16 1969</u>		<u>Alfred R. Lapin</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08824		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08818	
Item 6 Film 413 6/23/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) Mary Margaret Hendrick			2a. DATE OF DEATH Month 6 Day 14 Year 69		2b. HOUR 3:10 PM
3 SEX Female	4. RACE White	5. DATE OF BIRTH 7-15-07		6. AGE (In years last birthday) 62 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's County Md.		
10. CITY OR TOWN OF DEATH Lanham.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Magnolia Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) 1130 Branch Ave. S.E.	
13a. USUAL RESIDENCE (Where deceased lived or institution on admission) STATE Wash. D.C.		13b. CITY OR TOWN Wash. DC.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last John Savage		15. MOTHER'S MAIDEN NAME First Middle Last Katie McCallen		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO 578.05.1435		17 INFORMANT Ralph A. Hendrick		Address same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanoma DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mths 3 wks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5-27 , 19 69 , to 6-14 , 19 69 , that (I) (we) last saw the deceased alive on 6-14 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-14-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6.17.69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City or Town) (County) (State) Suitland Maryland		23e. REC'D BY REGISTRAR JUN 17 1969			
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08825

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08819

1 DECEASED NAME (Type or print) Robert L. Henry			2a DATE OF DEATH Month 6 Day 28 Year 69			2b. HOUR 6:25 A.			
3 SEX Male		4. RACE White		5. DATE OF BIRTH 5/25/88		6 AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges Md			
10. CITY OR TOWN OF DEATH Glenn Dale, Md.		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Glenn Dale Hospital		12a USJA. OCCUPAT ON (Kind of work done during most of working life, even if retired.) Retired (unknown)		12b KIND OF BUSINESS OR INDUSTRY --			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before adm-ssion) STATE D.C.		13b COUNTY 13		13c CITY OR TOWN Wash. D.C.		13d INSIDE CITY LIM 1SP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2 Chesapeake St., S. W.	
14. FATHER'S NAME First Phillip Middle Henry Last Custer			15 MOTHER'S MAIDEN NAME First Cecelia Middle Custer Last Custer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO. 578-01-7712		17 INFORMANT Decedent		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebral vascular accident (thrombosis) DUE TO, OR AS A CONSEQUENCE OF Old cerebral vascular accident, right, with left hemiplegia (b) 7 months DUE TO, OR AS A CONSEQUENCE OF Generalized arteriosclerosis (c) years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary tuberculosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 6/19/1968 , to 6/26/1969 , that (X) (we) last saw the deceased alive on 6/26/1969 , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Moe Weiss				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/26/69			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22e. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.					
23a. BURIAL		23b. DATE June 28/1969		23c. NAME OF CEMETERY OR CREMATORY Port Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland			
24. FUNERAL DIRECTOR Glenn Dale Hospital				25a. REC'D BY REGISTRAR JUN 30 1969		25b. REGISTRAR'S SIGNATURE Glenn Dale Hospital			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		AMOUR	
Lena		M.		Hicks				Month 06 Day 18 Year 69		11:00 PM	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN	
Female		Caucasian		4-30-04 1893		76 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
North Carolina		U.S.A.				Prince Georges County, Md.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						12a. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale		Eugene Leland Mem. Hosp.						Housewife		Own Home	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland		Prince Georges		Hyattsville				6948 Decatur Place			
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
Alfred		Moore						Nellie		Lucas	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Address							
no		213-56-4901		Hilda Elliott Same as #13							
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Sudden	
DUE TO, OR AS A CONSEQUENCE OF										myocardial infarction	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										Arterio-sclerotic Heart 3 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b)										Gen arterio-sclerotic ?	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Diabetes & obesity											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No. City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from June 18, 1966, to June 18, 1969, that (I) (we) last saw the deceased alive on June 18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
L W Malin		MD.						6-18-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
L W MALIN MD.		Riverdale, Md.									
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6/22/69		Lucas Cemetery		Lucama Wilson N.C.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Francis Gasch's Sons		Hyattsville, Md.		JUN 20 1969		K. M. Jones					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08827		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08821	
Item 6 Film 413 6/18/69 kk							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2c. DATE OF DEATH Month Day Year	
Maude					Hill	June 8, 1969	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		White		12-18-79		77 89 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
New York		U S A				Prince George's Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Cheverly			Prince George's Gen. Hosp.				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before address on) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS OF CITY LIMTS? YES <input type="checkbox"/> NO <input type="checkbox"/>
New York MD			Prince George's		Plain View		13e. STREET AND NUMBER
							16 Sunrise Street
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
						First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		
			091-10-43270		Doris K. Hill 259 Address 5127 1st St Bkto. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism							
DUE TO, OR AS A CONSEQUENCE OF (b) stasis post cholecystectomy							7 days
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (this hospital) attended the deceased from June 2, 1969, to June 8, 1969, that (we) last saw the deceased alive on June 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
Antonio B. Valentin, M.D.				6/9/69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Prince George's General							
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		6-11-69		Fairmount Cem		Newark N.J.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. J. Trubner & Sons				JUN 13 1969		Charles Judge	



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MEDICAL CERTIFICATION

08828										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08822									
Item #7a,b, Film G414 7/7/69 km										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Alma Louise Hines										Month June 26, Year 1969					M														
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS														
Female			White			03-26-05			64 YRS			MONTHS DAYS HOURS MIN																	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
North Carolina			USA						Prince George's Md																				
10. CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a USUAL OCCUPATION (Kind of work done during most of workweek, even if retired)					12b KIND OF BUSINESS OR INDUSTRY														
Cheverly					Prince George's Gen. Hosp.					Housewife																			
13a USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE					13b COUNTY					13c CITY OR TOWN					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER									
MD					Prince George's					New Carrollton					YES <input type="checkbox"/> NO <input type="checkbox"/>					7606 Fountainbleau									
14 FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
William Melton					Georgia S. Boone																								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)					16b SOCIAL SECURITY NO					17 INFORMANT Address																			
										Frances Hines, As 13 E																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>																													
4109 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) <u>acute coronary thromboses</u>																			
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?					20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
June 3, 1969					Removal of dead					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from June 5, 1969, to June 26, 1969, that (I) (we) last saw the deceased alive on June 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b SIGNATURE <u>Dr. B. Comer</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c DATE SIGNED June 26, 1969																			
22d PHYSICIAN'S NAME (Type)										22e ADDRESS																			
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE					23c NAME OF CEMETERY OR CREMATORY					23d LOCATION (City or Town) (County) (State)														
Burial					6/30/69					Cedar Hill Cemetery					Suitland, Md.														
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308-Suitland, Rd., Suitland, Md.										25a REC'D BY REGISTRAR JUN 30 1969 DATE					25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4123

16

VR A15 (4)
45M - 1/69

08829

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08823

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
Hilda Adel Holcombe						Month June Day 16 Year 1969			4:30 A.M.			
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		02-09-14		55 YRS.		MONTHS DAYS		HOURS MIN.		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						
Maryland		U.S.A.				Prince George's Md						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work no. life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George's Gen. Hosp.			Housewife			-			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD			Prince George's Mt. Rainier					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4004 36th Ave. St.		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last Charles E. Ensor			First Middle Last Florence B. DeBus									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO			17 INFORMANT Address Box 406-Rt. 4						
						Mrs. Calvin S. Hicks- Baltimore, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4123 Severe stenosing												
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) Coronary artery disease with cardiac arrest												
DUE TO, OR AS A CONSEQUENCE OF (c) embolic to heart since certain												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1b)						
21d INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or RFD No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from July, 1967, to 6/16, 1969, that (we) lost the deceased alive on 6/16/69, 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death												
22b SIGNATURE						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 6/17/69			
22d. PHYSICIAN'S NAME (Type) Leon Levitsky, M.D.						22e. ADDRESS Rhode Island, Mt. Rainier, MD						
23a BURIAL, CREMATION, or other disposition			23b. DATE 6/19/69			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.			23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.			
24 FUNERAL DIRECTOR Valley's Funeral Home Inc.						ADDRESS Mt. Rainier, Maryland			25a. REC'D BY REGISTRAR JUN 20 1969		25b. REGISTRAR'S SIGNATURE	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 10-101. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08830

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08824

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Robert Patrick Hughes						Month Day Year			19 8:30 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 1 YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
Male	White	12-15-1942	26 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year			19 8:30 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Pittsburgh, Penn.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Mgr. Service Station -					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's			Bowie			13e STREET AND NUMBER Stirrup 12402 Stirrup Lane		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Joseph E. Hughes			Irene M. Jones								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS					
No			169-32-6188			Carol Hughes (above address)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock (Wife)											
Multiple pellet wounds of abdomen											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				6:30 PM 6-24-19 69				Shot during altercation			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f LOCATION Street or RFD No City or Town County State			
				Box 40, Lancaster Lane, Bowie, Prince George County, Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				6-24-69			
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
Riverdale, Md.											
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial				6/30/69		Mt. Carmel Cem.		Pittsburgh, Pa.			
24 FUNERAL DIRECTOR						25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Nalley's Funeral Home Inc.						DATE JUN 30 1969		Maryland			

08831

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

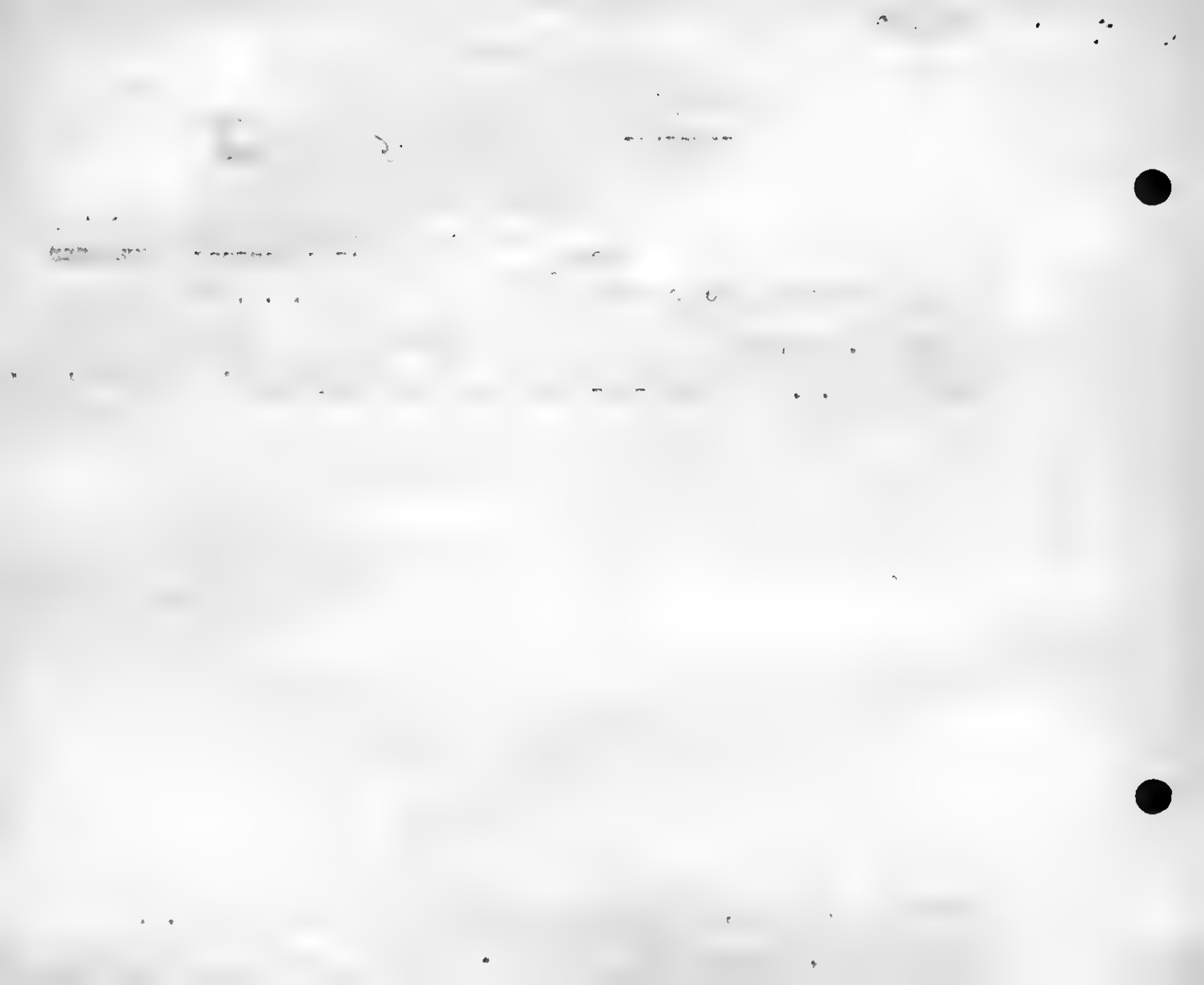
08825

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) WALTER First Harold Middle XA Last HUNTER		2a. DATE OF DEATH 6 Month 21 Day 19 Year 69		2b. HOUR 12:42 PM
3. SEX MALE	4. RACE CAUCASIAN White	5. DATE OF BIRTH 5/26/95		6. AGE 74 YRS.
7a. BIRTHPLACE (State or foreign country) WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Married DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH PRINCE GEORGES	
10. CITY OR TOWN OF DEATH FORESTVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home	12a. USUAL OCCUPATION (Kind of work done during last year) Restaurateur, Owner	12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. CITY OR TOWN Anne Arundel	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D. 2142	
14. FATHER'S NAME First James W. Middle Hunter Last Hunter		15. MOTHER'S MAIDEN NAME First Adeline Middle Mercer Last Mercer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO W.W.1 577-10-1561	17. INFORMANT 609 Horncrest Rd. Baltimore, Md. William Alton Hunter		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) CEREBRAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DUODENAL ULCER (PERFORATED) - POST. OPERATIVE				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 6-17-1969 , to 6-21-1969 , that (I) (we) lost saw the deceased alive on 6-20-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.				
22b. SIGNATURE Oliver B. Bond MD	22c. PHYSICIAN'S NAME (Type) OLIVER B. BOND MD	22d. ADDRESS 7420 MARLBORO PIKE FORESTVILLE MARYLAND 20028	22e. DATE SIGNED 6-21-69	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	June 24, 1969	Rock Creek Cemetery	Washington D.C.	
24. FUNERAL DIRECTOR Ritchie Bros. Funeral Home		25a. REC'D BY REGISTRAR JUL 7 1969	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08832											
08826											
1. DECEASED-NAME (Type or print) First <u>Michael</u> Middle <u>Joseph</u> Last <u>Hysan</u>					2a. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1969</u>					2b. HOUR <u>5:20</u> PM	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>06-21-69</u>			6. AGE (In years last birthday) YRS <u>1</u> MONTHS <u>1</u> DAYS <u>1</u>		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS <u>30</u> MIN <u>20</u>		
7a. BIRTHPLACE (State or foreign country) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George's</u> Md.					
10. CITY OR TOWN OF DEATH <u>Cheverly</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince George's Gen. Hosp.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased admission) STATE <u>MD</u>			13b. RESIDENCE BEFORE COUNTY <u>Prince George's</u>		13c. CITY OR TOWN <u>Hillside</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>1203 / 57th Avenue</u> <u>Larchmont</u> Ave.		
14. FATHER'S NAME First <u>Harold</u> Middle <u>Gene</u> Last <u>Kahre</u>			15. MOTHER'S MAIDEN NAME First <u>Dorothy</u> Middle <u>Lee</u> Last <u>Hysan</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Post-maturity (expected date of birth May 21)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Endocarditis - tricuspid valve</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Etiology to be determined</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>June 21, 1969</u> , to <u>June 22, 1969</u> , that <u>he</u> (we) last saw the deceased alive on <u>June 22</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Patrick A. Reardon</u>						DEGREE ATTENDING <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS.		22c. DATE SIGNED <u>6-22-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Patrick A. Reardon, M.D.</u>						22e. ADDRESS <u>9430 Lanham-Severn Rd., Seabrook, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>6-28-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pr. George's Gen. Hosp.</u>				23d. LOCATION (City or Town) (County) (State) <u>Cheverly, Pr. George's, Md.</u>			
24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr., Adminis.</u>				ADDRESS		25a. REG'D BY REGISTRAR DATE <u>JUL 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08833					08827				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First		Middle		Last		Month		Day	
Ethel		B		Jefferson		June		23	
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR	
				6-15-1897		72 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Wash. D.C.						Prince Georges Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (Give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hyattsville		6500 Riggs Rd. Nursing Home							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Wash. D.C.		135 COUNTY				2705 13th St. Apt. 333			
14. FATHER'S NAME (Type or print)		15. MOTHER'S MAIDEN NAME (Type or print)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT	
William H. Bannister		Nancy Twyman						Harry Jefferson-husband-same as above	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONITIS</u>									
4339 DUE TO, OR AS A CONSEQUENCE OF (b) <u>NEUROLOGICAL IMPAIRMENT + NASOGASTRIC TUBE</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRAL VASCULAR THROMBOTIC DISEASE</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <u>5/2</u> , 19 <u>69</u> , to <u>6/23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/23</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
<u>Edw. J. Mehlman</u>		<u>6/23/69</u>		DR. EDWARD MEHLMAN					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		<u>6/27/69</u>		Lincoln Memorial Cemetery		Maryland			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26. DATE			
<u>John J. Stewart</u>		<u>Mr. E. J. Jun 27 1969</u>		<u>Charles Judge</u>		<u>27</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

08834

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10320

1 DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR		
		Johnson			June 24 1969			3:30A M		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male	Colored		06-23-69		— YRS.		1 7 5			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
MD		2858				Prince George's Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			Prince George's		Bowie		YES <input type="checkbox"/> NO <input type="checkbox"/>		131 12th Street	
14 FATHER'S NAME			First	Middle	Lost	15 MOTHER'S M A D E N NAME		First	Middle	Lost
Clarence			L	Johnson		Charlotte				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
NO										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Prematurity.</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prematurity / Labor.</u>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or RFD No. City or Town County State						
22a. I certify that <u>xx</u> (this hospital) attended the deceased from <u>June 23, 1969</u> , to <u>June 24, 1969</u> , that <u>xx</u> (we) last saw the deceased alive on <u>June 24, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Ricardo Scartscini</u>				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
								June 26, 1969		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
Ricardo Scartscini, M.D.				Prince George's Gen. Hosp.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
		7-11-69		Prince George's General Hosp.		Cheverly PG Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Harvey W. Penn, Jr., Admin.						JUL 15 1969		<u>Ricardo Scartscini</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4369

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08835		CERTIFICATE OF DEATH						08828	
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Bertha M Johnson						6 19 69			1:27 PM
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Female		White		1-28-80			89 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Va		U S A				Prince George's County Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			P.G.G.H. - E.C.F.			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - H 15?		13e. STREET AND NUMBER
Maryland			Prince George's		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12803 Beaverdale Lane
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William H. Barrett			Emily Gale						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
no			no		231.62.021 Mrs Edward White same as #13e				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									
4317 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from June 10, 1969 to June 19, 1969, that (I) (we) last saw the deceased alive on June 19, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
							6/19/69		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					Prince George's Gen. Hosp., Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6.23.69		Cedar Hill Cemetery		Suitland Maryland			
24. FUNERAL DIRECTOR ADDRESS					25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Lee Funeral Home. 300 4th st N E					JUN 23 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 153
45M

<div>08836</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 6 Film 414 7/1/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>08829</div>											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
HARRIE			G. Johnson			Month 6 Day 23 Year 69			2 12 PM		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		6-29-89		18 5/79 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wash., DC		USA				Prince George		Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Hyattsville			Hyattsville, Md								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. USUAL CITY LIMITS?		
md.			Pr. Geo.			Greenbelt			YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER			13f. STREET AND NUMBER								
52 Crescent Rd.			52 Crescent Rd.								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Charles			Dorothy			Grey, Katherine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT					
						V. Conner 2113 Guilford Rd, Hyattsville, Md					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Occlusion										one week	
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Cardiac Vascular Disease											
DUE TO, OR AS A CONSEQUENCE OF (c) Exposed Atherosclerosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> at work <input type="checkbox"/> at home											
22a. I certify that (I) (this hospital) attended the deceased from 1300 to 23 June 69, that (I) (we) last saw the deceased alive on 23 June 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. DATE SIGNED		
Robert H. Fuller MD						35 NEW YORK AVE. N.W. Wash DC			6-23-69		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			June 26/69			Lodestar Hill Cem Suitland Md					
24. FUNERAL DIRECTOR			25a. REC'D BY REG-STRAR			25b. REC-STRAR'S SIGNATURE					
J. F. Costello 1722 N Capitol St			JUN 26 1969			J. Costello					

08837

CERTIFICATE OF DEATH

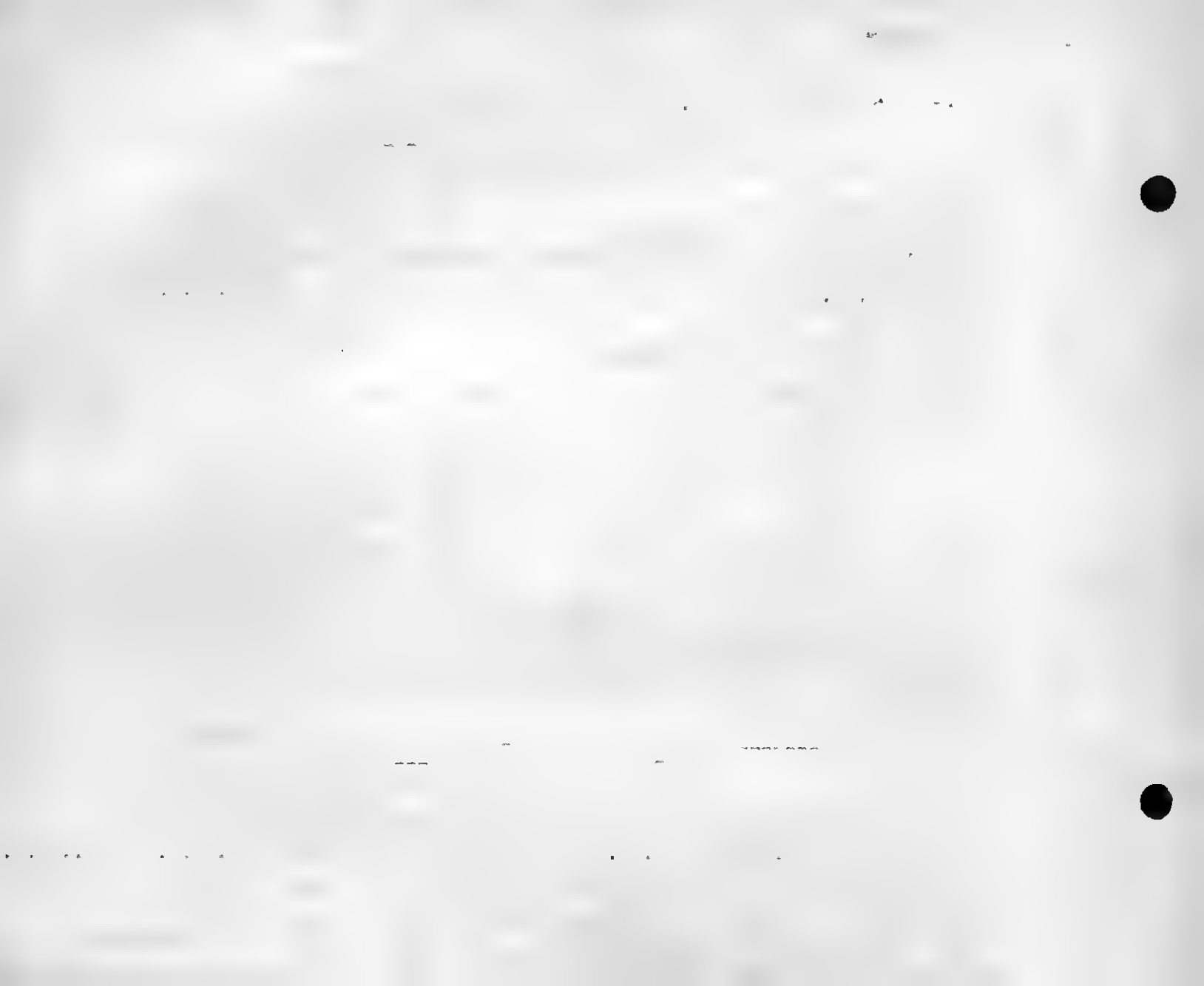
08831

1 DECEASED-NAME (Type or print) William T. Jones			2a DATE OF DEATH Month 6 Day 23 Year 69			2b HOUR M			
3 SEX M		4 RACE Negro		5 DATE OF BIRTH 7-4-19		6 AGE (In years last birthday) 58 YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Hope, Arkansas		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md			
10 CITY OR TOWN OF DEATH Clinton, Maryland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pineview Gardens Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer		12b KIND OF BUSINESS OR INDUSTRY Private			
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE D. C.		13b COUNTY Washington		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1707 H St. N.E. #3	
14 FATHER'S NAME First Price Middle Jones Last			15 MOTHER'S MAIDEN NAME First Not stated Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b SOCIAL SECURITY NO. None		17 INFORMANT Elizabeth Jones - Wife		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ca - prostate DUE TO OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown unknown	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) arthritis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from 4-9-69 , 19____, to 6-23-69 , 19____, that (I) (we) last saw the deceased alive on 6-20-69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE Henry G. Hadley, M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 20032			
22d PHYSICIAN'S NAME (Type)		23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 6-26-69		23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d LOCATION (City or Town) (County) (State) Prince George, Md	
24 FUNERAL DIRECTOR John Rhines Company Funeral Home				25a REC'D BY REG STRA JUN 26 1969		25b SIGNATURE John Rhines			
3015 12th Street, N. E., Washington, D. C.				DATE					

185X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

088335

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

088332

1. DECEASED-NAME (Type or print) First Middle Last Cleon L. Karschner			2a. DATE OF DEATH Month Day Year June 27th 1969			2b. HOUR 7-a M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 16th, 1901		6. AGE (in years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIAGE STATUS MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md	
10. CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Manor Care Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Naval Gun Factory		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Cleon C. Karschner		15. MOTHER'S MAIDEN NAME First Middle Last Eva. Weaver		16. SOCIAL SECURITY NO.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown] no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address A. Rebecca Karschner (Wife) Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ischemic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Catarrh of prostate & metastases</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-21, 1969</u> , to <u>6-27, 1969</u> , that (I) (we) last saw the deceased alive on <u>6-26, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Morton A. H. Schuler, MD				22c. DATE SIGNED 6-27-69			
22d. PHYSICIAN'S NAME (Type) Morton A. H. Schuler, MD				22e. ADDRESS 9205-New Hampshire Ave. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 30/69		23c. NAME OF CEMETERY OR CREMATORY Port Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.				25a. REC'D BY REGISTRAR Wash. DC.		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08839

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08839

1 DECEASED NAME (Type or Print)			First Grace			Middle May			Last Kennedy			2a DATE KNOWN OF ESTI- DEATH MATED			Month 16-5-69			Day 19			Year 1969			2b HOUR 10am					
3 SEX Female			4 RACE White			5 DATE OF BIRTH 6-25-1900			6 AGE (in years last birthday) 68 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN			2c DATE PRONOUNCED DEAD Month 6			Day 5			Year 69			2d HOUR 1:35am		
7a BIRTHPLACE (State or foreign country) Virginia			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Prince George's Md.																				
10 CITY OR TOWN OF DEATH Cheverly						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Hospital						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife						12b KIND OF BUSINESS OR INDUSTRY											
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland						13b COUNTY Prince George's						13c CITY OR TOWN Landover Hills						13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						13e STREET AND NUMBER 3817 Thornwood Road					
14 FATHER'S NAME Cary						First Belton						15 MOTHER'S M.A.DEN NAME Virginia						First (Unknown)											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16b SOCIAL SECURITY NO (If yes give war or dates of service) -						17 INFORMANT Shirley Kennedy (above address)																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Hypertensive arteriosclerotic heart disease over 6 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a DATE OF OPERATION												19b CONDITION FOR WHICH OPERATION WAS PERFORMED?												20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No City or Town County State																	
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD						Riverdale, Md.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)						22b DATE SIGNED 6-6-69											
23a BURIAL, CREMATION, REMOVAL (Specify)						23b DATE 6/9/69						23c NAME OF CEMETERY OR CREMATORY Crown Hill Cem.						23d LOCATION (City or Town) Clifton Forge, Va.											
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.						ADDRESS Mt. Rainier, Maryland						25a RECD BY REGISTRAR DATE JUN 9 1969						25b REGISTRAR'S SIGNATURE Charles Judge											



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in part 1 in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with term PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08840

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08834

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI DEATH MATED			Month Day Year			2b HOUR																							
Roger			Allen			Kennedy			6-10-69			1910:30pm																							
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost (birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR																				
Male		White		9-24-1946		22 YRS						Month Day Year			6 10 69 19 11:45pm																				
7a BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH				Md.																			
Va.				U. S. A.								Prince George's																							
10. CITY OR TOWN OF DEATH						11 NAME OF HOSPITAL OR INSTITUTION (if not in hosp. tal give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b KIND OF BUSINESS OR INDUSTRY																	
Cheverly						Prince George Hospital						Laborer																							
13a USUAL RESIDENCE (Where deceased lived, if institut on; Res dence before address on) - STATE						13b. COUNTY						13c CITY OR TOWN						13d INSIDE CITY LIMITS?						13e STREET AND NUMBER											
Maryland						Prince George's						Beltsville						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						11704 Robey Avenue Apt 1											
14 FATHER'S NAME						First Middle Last						15 MOTHER'S MAIDEN NAME						First Middle Last																	
Unknown												Rose						Ingram																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO (If yes give war or dates of service)						17 INFORMANT						ADDRESS																	
no						213 46 8696						Rose Kennedy						Same as #13																	
18 CAUSE OF DEATH (Enter any one cause per line for (a) (b) and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Electrocution</u>																																			
7259 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																			
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																																			
(c) _____ DUE TO, OR AS A CONSEQUENCE OF																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?																							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
21a EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day Year HOUR A.M.						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																							
						10:30am 6-10- 1969						Touched high voltage wire																							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e PLACE OF INJURY (At-home, farm, street, factory, office building, etc)						21f LOCATION Street or R.F.D No City or Town County State																							
						Odell Road, Beltsville						Prince George County, Maryland																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																																			
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED																							
EXAMINER'S NAME (Type)						John Kehoe MD Riverdale, Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																							
												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																							
												ADDRESS (Street, city, town, or county)																							
23a BURIAL, CREMATION, REMOVAL (Specify)						23b DATE						23c NAME OF CEMETERY OR CREMATORY						23d LOCATION (City or Town) (County) (State)																	
Burial						6/15/69						Bells Valley						Bells Valley Rockbridge Va																	
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR DATE												25b REGISTRAR'S SIGNATURE											
Francis Gasch's Sons Hyattsville, Md.												JUN 16 1969												[Signature]											

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08841										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08835																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																							
1. DECEASED-NAME (Type or Print)					First Middle Last					2a. DATE KNOWN OF DEATH					2b. HOUR																								
Calvin Beuford Kincaid										Month Day Year					2d. HOUR																								
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD					2d. HOUR																						
Male		White		11-16-1898		70 YRS		MONTHS DAYS		HOURS MIN		Month Day Year					2d. HOUR																						
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED					9. COUNTY OF DEATH					Md																			
Tenn.					U. S. A.					WIDOWED					Prince George's																								
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY																								
Cheverly					Prince George Hospital					General Ret. Passenger Agent Railroad																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before last admission) STATE					13b. COUNTY					13c. STREET AND NUMBER																													
Maryland					Prince George's					Hyattsville					4201 Tuckerman Street																								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																																		
William Henry Kincaid					Mary Elizabeth Hunter																																		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					2722 Randolph Road					Wheaton, Md. 20902																			
no					718 16 8961					John B. Kincaid																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock																																							
DUE TO, OR AS A CONSEQUENCE OF Bronchopneumonia																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																																							
(b) Multiple pulmonary emboli																																							
DUE TO OR AS A CONSEQUENCE OF Traumatic transection of spinal cord																																							
(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																			
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
										PM 5-24-1969										Fell down steps																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No City or Town County State																			
										home										same as #13																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER										22b. DATE SIGNED																			
EXAMINER'S NAME (Type)										ASSISTANT MEDICAL EXAMINER										6-11-69																			
John Kehoe MD										Riverdale, Md.										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
										ADDRESS (Street, city, town, or county)																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)									
Burial										6/15/69										Ft. Lincoln										Colmar Manor P. G. Md.									
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REG. STR.										25b. REGISTRAR'S QUAL. RE.									
Francis Gasch's Sons										Hyattsville, Md.										JUN 16 1969										Marko Page									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

jwb

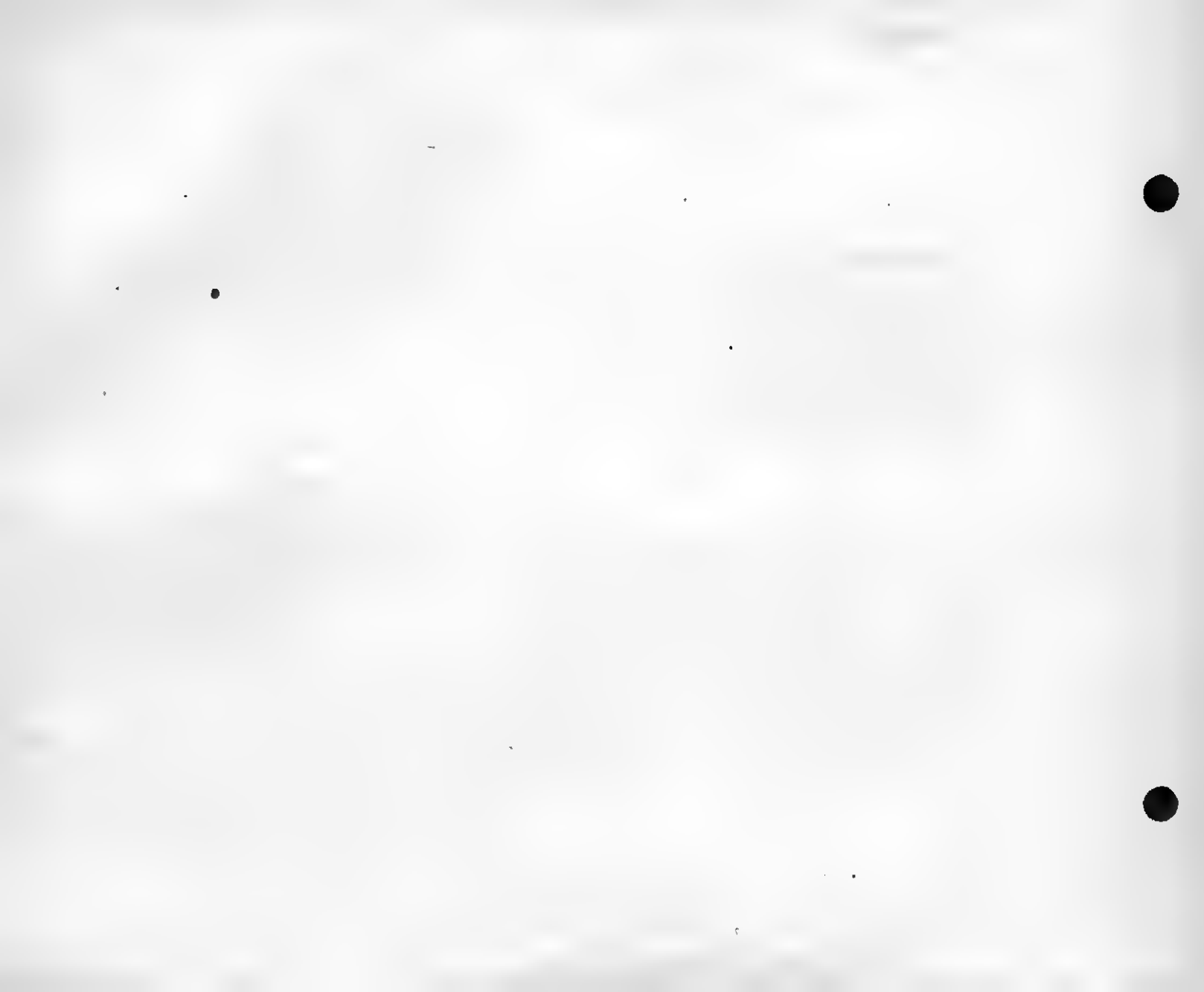
VR A15ME (5,
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08842		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						08836		
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH	2b HOUR
Allen			G		Kitchen				<input checked="" type="checkbox"/> Month	Day
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7c DATE PRONOUNCED DEAD	
Male			White		11-24-1923		45 YRS		6 Month 10 Day 69 Year 198:40pm M	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH		
Maryland			U. S. A.					Prince George's Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			2b KIND OF BUSINESS OR INDUSTRY	
Riverdale			Leland Memorial Hospital			Mechanic			Automobile	
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY, MTS?	
Maryland			Prince George's			Beltsville			YES <input type="checkbox"/> NO <input type="checkbox"/>	
4 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME	
William D. Kitchen									Mary P. Arrowsmith	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS	
No			216 16 9392			Hosp. Records			Riverdale, Md.	
18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple system metastases										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last										
(b) Carcinoma of lung										unknown
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY?
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item B)				
			HOUR A M P.M. 19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED	
			John Kehoe MD			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			6-11-69	
			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			6/13/69		Ft. Lincoln Cemetery			Colmar Manor P. G. Md.		
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE
Francis Gasch's Sons						Hyattsville, Md.		JUN 17 1969		Richard Judge

1621
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08843										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08837																													
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last										Month Day Year										PM																													
Earl Kenneth Kline										06 24 69										6:10																													
3 SEX										4 RACE										5. DATE OF BIRTH																													
Male										Caucasian										1-25-13																													
7a BIRTHPLACE (State or foreign country)										7b CITIZEN OF WHAT COUNTRY?										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9 COUNTY OF DEATH																			
Pennsylvania										U.S.A.										Prince Georges County, Md.																													
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																			
Riverdale										Eugene Leland Mem. Hosp.										Laborer																													
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) - STATE										13b. COUNTY										13c CITY OR TOWN										13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										13e STREET AND NUMBER									
Maryland										Prince Georges										Hyattsville																				5301 Deatur Street									
14 FATHER'S NAME										15. MOTHER'S MAIDEN NAME										Address																													
First Middle Last										First Middle Last																																							
James K. Kline										Lizzy J. Russell																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)										16b SOCIAL SECURITY NO										17 INFORMANT										Address																			
No										183 12 7350										Kenneth E Kline										Hyattsville, Md.																			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Carcinomatosis										1 month																													
1621										DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Bronchogenic Carcinoma										3 months																													
										(c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 6-23, 19 69, to 6-24, 19 69, that (I) (we) last saw the deceased alive on 6-24, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE										C.J. Houmann										DEGREE										ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 6-24-69									
22d. PHYSICIAN'S NAME (Type)										C.J. Houmann, MD										22e. ADDRESS										Riverdale, Maryland 20840																			
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
Burial										June 27, 1969										Ft Lincoln Cemetery										Colmar Manor Pro Geo Md.																			
24. FUNERAL DIRECTOR										ADDRESS										25a. RECD. BY REG. STRAR										25b. REG. STRAR'S SIGNATURE																			
F. Gasch's Sons										Hyattsville, Md.										JUN 27 1969										J. Charles Judge																			

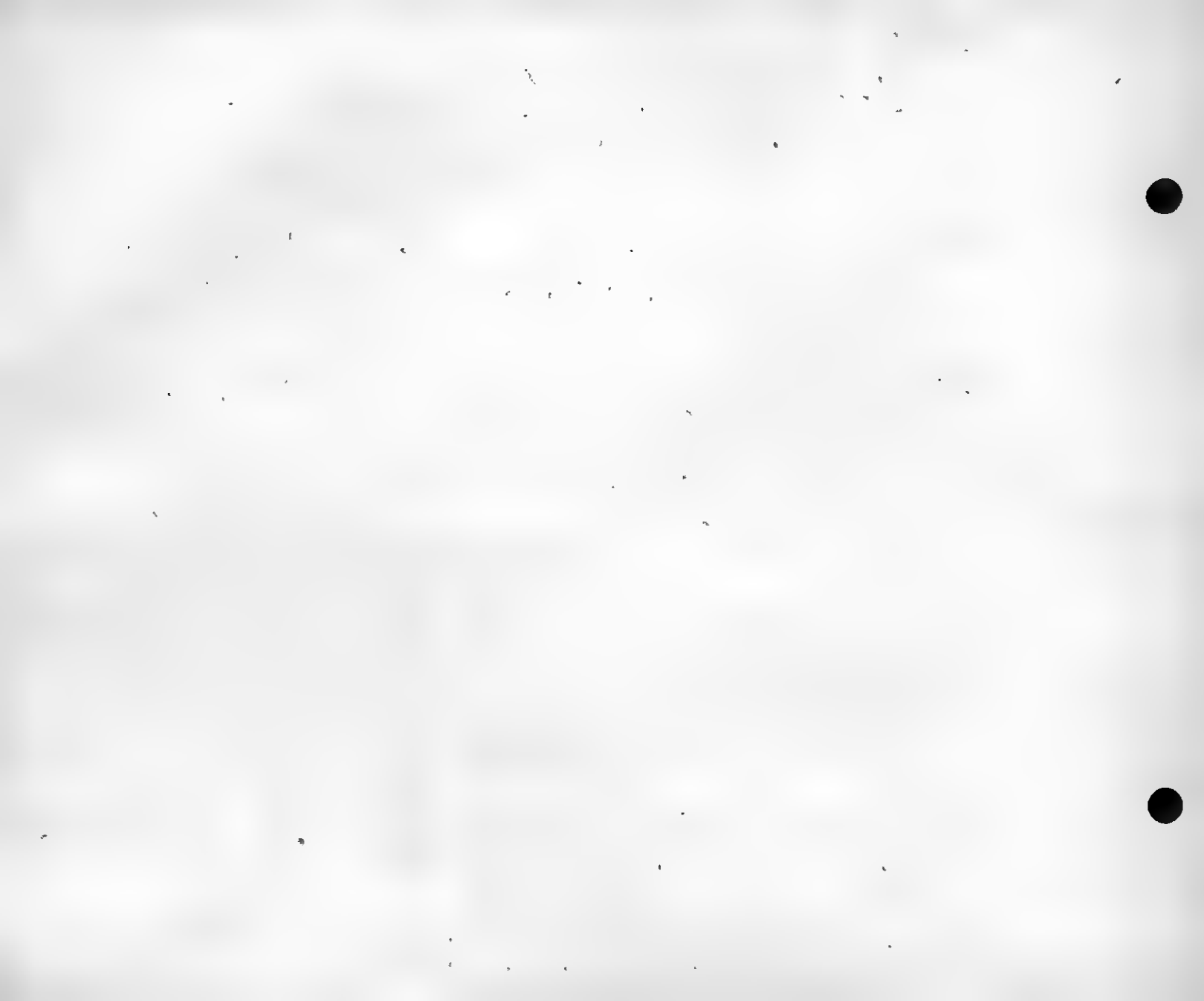


**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) STEPHEN PETER KOMAREK		Middle		Last		2a. DATE KNOWN OF DEATH ESTIMATED June 21 1969		2b. HOUR 2:45 PM	
3 SEX M	4 RACE W	5. DATE OF BIRTH 4-14-1938		6 AGE (in years last birthday) 30 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0	8 UNLHR 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month June Day 21 Year 1969		2d. HOUR 3:15 PM
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges			
10. CITY OR TOWN OF DEATH Andrews Air Base		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Andrews Air Base Hosp		12a. U.S.A. OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY Army Sergeant			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b. COUNTY Prince Georges		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 5523 Alice Ave	
14. FATHER'S NAME unk				15. MOTHER'S MAIDEN NAME unk					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? yes				16b. SOCIAL SECURITY NO unk		17. INFORMANT Josephine Komarek			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Coronary Thrombosis									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Arterio Sclerosis of Coronary									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Arteriosclerosis									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Dayton O Watkins		EXAMINER'S NAME (Type) DAYTON O WATKINS		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS Simmons Bros. 1661-Gd. Hope Rd. SE. DC.		22b. DATE SIGNED 6-22-69		ADDRESS (Street, city, town, or county)					
23a. BURIAL PERMIT NO. 6-22-69		23b. DATE June 24, 69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) Arlington, Va.		(County) (State)	
24. FUNERAL DIRECTOR Simmons Bros		ADDRESS Wash.		25a. RECD BY REGISTRAR JUN 25 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08845 CERTIFICATE OF DEATH 08839										
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	2b. HOUR
Fay			S.		Langhenry				Month June	Day 24
3. SEX			4 RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female			Caucasian		May 4, 1903		66 YRS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Wash., D.C.			U.S.A.				Prince Geo.		Greenbelt	
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		13a USUAL RESIDENCE (Where deceased admission) STATE		13b COUNTY	
Greenbelt Convalescent Home			Ret. - Treasury Dept. -				Maryland		Pr. Geo.	
13c CITY OR TOWN			13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Avondale			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2008 - Woodreeve Rd.		First Middle Last		First Middle Last	
William B. Clemmer			Margaret McCandlish							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT		Address		2704-Allison	
No					Eunice Clemmer - St., Mt. Rainier, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiorespiratory failure</u>										<u>various</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma</u>										<u>9 months</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>bronchogenic carcinoma</u>										<u>10 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION			Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 8-19, 1968, to 6-25, 1969, that (I) (we) last saw the deceased alive on 6-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED
Paul A. DeVore										6-25-69
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS				
PAUL A. DEVORE, M.D.						3415 HAMILTON ST Hyattsville Md				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial			6/27/69		Cedar Hill Cem.		Suitland, Md.			
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE
Nalley's Funeral Home Inc.						Mt. Rainier, Maryland		JUN 30 1969		Charles Judge

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

08846

08840

4153

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-17-69 19 9:15a				2b HOUR			
James		Langley													
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE, in years (last birthday)		7 UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month 6 Day 17 Year 69 19 10:02a				2d HOUR			
Male	White	12-5-1890		78 YRS											
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						Md.			
WASH. D. C.		U. S. A.				Prince George's									
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY									
Cheverly		Prince George Hospital		McBurney Mechanic		DIS. OF COLUMBIA									
13a USUAL RESIDENCE (Where deceased lived, if inst. put on Residence before admission) - STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER							
Maryland		Prince George's		Seabrook				9316 Washington Blvd.							
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last	
JOSEPH H. LANGLEY								ROSA						JENKINS	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS									
NO		577-07-5207		ESTHER R. LANGLEY		NEW CARROLLTON MD.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
MEDICAL CERTIFICATION															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				John Kehoe MD Riverdale, Md.				22b. DATE SIGNED 6-18-69							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
BURIAL				JUNE 20, 1969				CONGRESSIONAL CEM.				WASHINGTON, D. C.			
24 FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REG. STRAR DATE				25b. REGISTRAR'S SIGNATURE			
W. W. CHAMBERS GO. RIVERDALE, MD.								JUN 20 1969							



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. My delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-25 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR
Charles		G		Lavin				6-11-69		12:16am
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	
Male	White	Jan 31, 1912		57 YRS					6 11 69 1:09am M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Illinois		USA				Prince George's Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital			Pgram Officer			H E W Dept	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER	
Virginia			Alexandria			YES			115 South St. Asaph St.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
John M Lavin			Louise Godefrin							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS				
yes			WW II			Virginia Lavin, 115 S St Asaph, Alexandria, Va				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock										
DUE TO, OR AS A CONSEQUENCE OF Bilateral hemothorax										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
(b) from Laceration of aorta										
DUE TO, OR AS A CONSEQUENCE OF Fracture of T-9										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Severe coronary artery sclerosis										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
				12:19pm 6-11-19 69		Driver of car involved in collision				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION: Street or RFD No		City or Town		County		State
		Rt. 4 near St. Rt. 223		Prince George County, Maryland						
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED
John P. H. C. River		JOHN KEHCT RIVER								6-11-69
23a BURIAL, CREMATION, REMOVAL		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		6/13/1969		Culpeper National Cem		Culpeper				Va
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Demaine Funeral Home, Alexandria, Virginia				JUN 17 1969		Charles Judge				

4124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08843

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08842

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
LILLIAN		I		LEARY	JUNE Month 12 Day 1969 Year		30 M		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		
FEMALE	WHITE		4/15/1892		77 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Massachusetts		U.S.				PRINCE GEORGES Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
CNEVERLY		PRINCE GEORGES EXTENDED CARE FACI		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		PG		BOWIE				12641 HEMING LANE	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
George Vocell		Ida Varney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
no				Eileen Avery, Daughter		12641 Heming Lane, Bowie, Md.			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>								<u>2 YEARS</u>	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>DIABETES + GANGRENE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>67</u> , to <u>JUNE</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>JUNE 11</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Norman K Bohrer MD</u>				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>June 12, 1969</u>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/16/69		St. Joseph		West Roxbury, Mass.			
24 FUNERAL DIRECTOR <u>Robert E. Wilkins</u>				ADDRESS <u>430 Suitland Rd., S.L., Suitland, Md. 20023</u>		25. REC'D BY REGISTRAR <u>JUN 19 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>08849</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 7 Film GL13 6/16/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>08843</div>												
1. DECEASED-NAME (Type or print) First Middle Last Junius Dargin Logan						2a. DATE OF DEATH Month Day Year June 5 1969			2b. HOUR 6:45A			
3 SEX Male		4 RACE Colored		5 DATE OF BIRTH 02-14-88		6 AGE (in years last birthday) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) S. Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md.						
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD				13b COUNTY Prince George's		13c CITY OR TOWN Fairmont Hgt.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 910 60th Avenue		
14. FATHER'S NAME First Middle Last Unknown				15. MOTHER'S M A DEN NAME First Middle Last Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO 1-10-12-12-578-16-1371A		17 INFORMANT Address Christine Logan 910-60th Ave.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 4123 DUE TO, OR AS A CONSEQUENCE OF (b) atrial fibrillation - congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME - ARM STREET FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (X) (this hospital) attended the deceased from May 14 1969 , to June 5 1969 , that (we) last saw the deceased alive on June 5 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Luis Bnetolila				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) Luis Bnetolila, M.D.				22e ADDRESS Prince George's General Hospital								
23a BURLIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>		23b DATE 6-9-69		23c NAME OF CEMETERY OR CREMATORY Lincoln Mem.				23d LOCATION (City or Town) (County) (State) Suitland, Md.				
24. FUNERAL DIRECTOR ADDRESS Rollins F.H. 4339 Hunt Pl. N.E. D.C.				25a REC'D BY REGISTRAR DATE JUN 11 1969		25b REGISTRAR'S SIGNATURE Richard J. Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical examiner notified and approved

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b HOUR
John				Loher				June 25 1969		5:51 PM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		White		May 28, 1903		66 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Germany		Germany				Prince George's Md				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince George's Gen. Hosp.		Carpenter		Building				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
MD.		Prince George's		Hyattsville		YES		5321 Crettenden		
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last
John Loher								Johanna Deisboeck		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address				
no		579 05 7423		Marie Loher		Hyattsville, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cornary Heart Disease</u>										
4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Disease</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>2-1</u> , 19 <u>60</u> , to <u>6-25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-2</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED				
A. R. Deitz, M.D.						6-26-69				
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS								
Aaron Deitz, M.D.		Prince George's Plaza		Hyattsville, MD						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		June 28, 1969		Mt Olivet Cemetery		Washington D C.				
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
F. Gasch's Sons		Hyattsville, Md.		JUN 30 1969		G. Charles Judge				

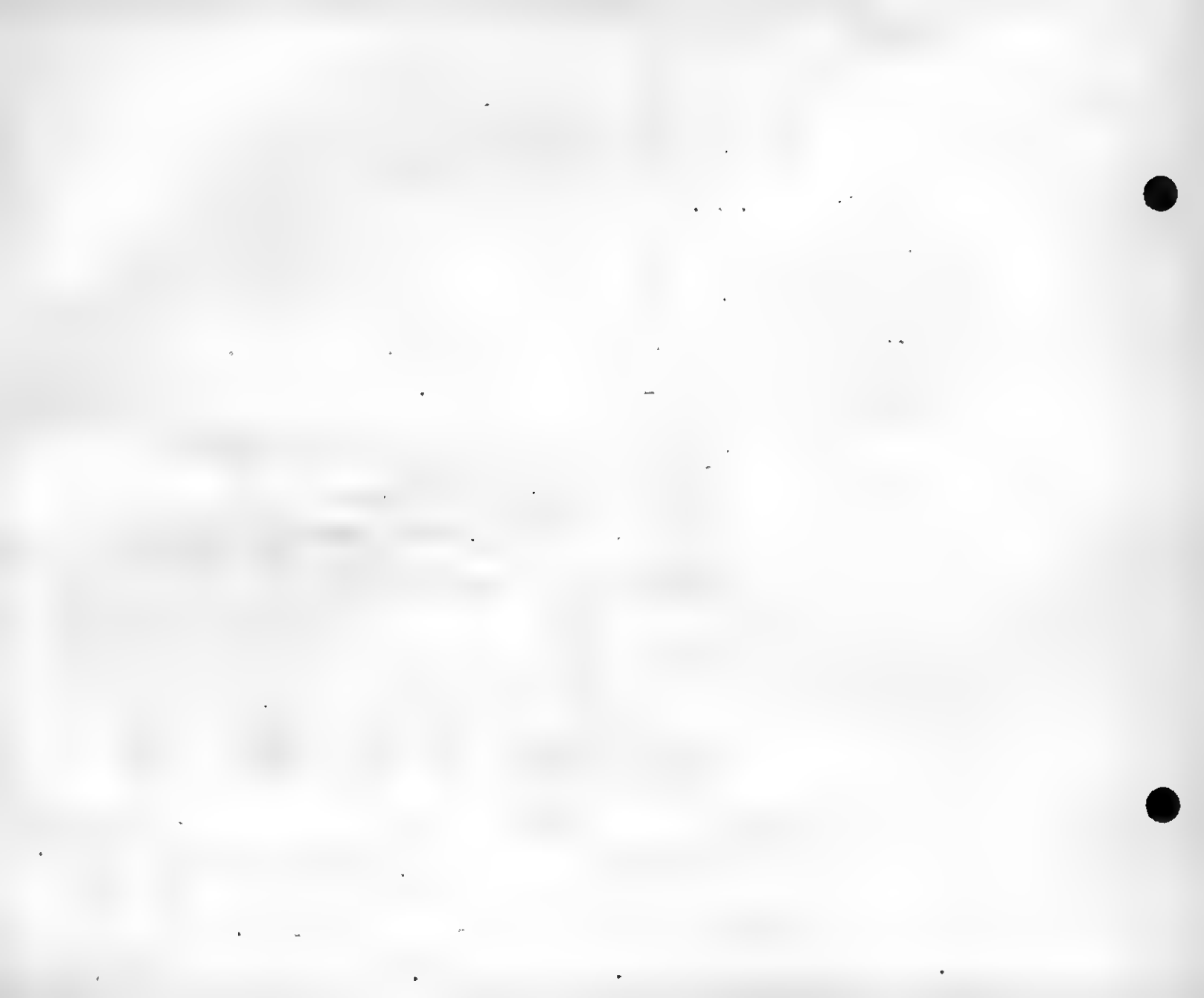
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

<div>Item 15 Film 414 7-9-69</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div>									
08851					08845				
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR
Maud			B.		Lowen	Month June Day 5 Year 1969			7:35A M
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
Female		White		08-16-88		80 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Wisconsin		U.S.A.				Prince George's Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.J.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp		School-teacher		School			
13a USUAL RESIDENCE (Where deceased lived, if institution; Res. den. before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MD		Prince George's		Lanham				4379 Van Buren St. Magnolia Gardens, Nursing	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Bernhart					Lowan	Anzella			V. Bardwell
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17. INFORMANT			Address		
No		398-44-1634		Olive L. Zeleny			(same)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Anemia, secondary to chr. dysphagia</i> DUE TO, OR AS A CONSEQUENCE OF <i>Chronic Hepatic failure</i> (b) <i>Ado arteriosclerotic cerebral vessel disease</i> DUE TO, OR AS A CONSEQUENCE OF <i>Ado arteriosclerotic cerebral vessel disease</i> (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<i>Anemia, secondary</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		21g CITY OR TOWN			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.		City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>21 May 1969</i> to <i>June 1969</i> , that (I) (we) last saw the deceased alive on <i>4 June 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
<i>W.L. Etienne, M.D.</i>		<i>6-5-69</i>		<i>W.L. ETIENNE</i>					
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS					
<i>College Park, Md</i>		<i>College Park, Md</i>		<i>College Park, Md</i>					
23a BURLIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		June 10, 1968		Three-Lakes Cemetery		Three-Lakes Vilas Wisconsin			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		25c REGISTRAR'S SIGNATURE	
F. Gasch's		4739 Baltimore Av. Hyattsville, Md		JUN 9 1969		<i>W. L. Etienne</i>		<i>W. L. Etienne</i>	

4379



08852

CERTIFICATE OF DEATH

08846

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 64 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 500 Fairlawn Ave.		d. STREET ADDRESS Fairlawn Ave.	
3. NAME OF DECEASED (Type or print) WILLIAM Fiege LUBER		4. DATE OF DEATH Month June Day 9 Year 19 69	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1905
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 69 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass. Gen Foreman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. Agriculture	
11. BIRTHPLACE (County & State, or foreign country) Prince George Co. Laurel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vivian P. Luber		14. MOTHER'S MAIDEN NAME Cecilia Fiege	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-10-5486	
17. INFORMANT Mrs. Nellie C. Luber		Address 500 Fairlawn Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO 1058 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) METASTASTIC ADENOCARCINOMA (c) CARCINOMA OF COLON		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 12/6 , 19 68 , to 5/3 , 19 69 , that (1)(we) last saw the deceased alive on 5/3 , 19 69 , and that death occurred at 10:32 p.m. , from causes and on the date stated above			
22a. SIGNATURE Pedro I. Matias		22b. DATE SIGNED 6/10/69	
22c. PHYSICIAN'S NAME (Type) Pedro I. Matias, M.D.		22d. ADDRESS 4712 Montgomery Place Beltsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/12/69	23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Laurel, Prince George Md.
24. FUNERAL DIRECTOR Laurel Funeral Home Inc. of Howard M. Fleck		25a. REC'D BY REGISTRAR JUN 16 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

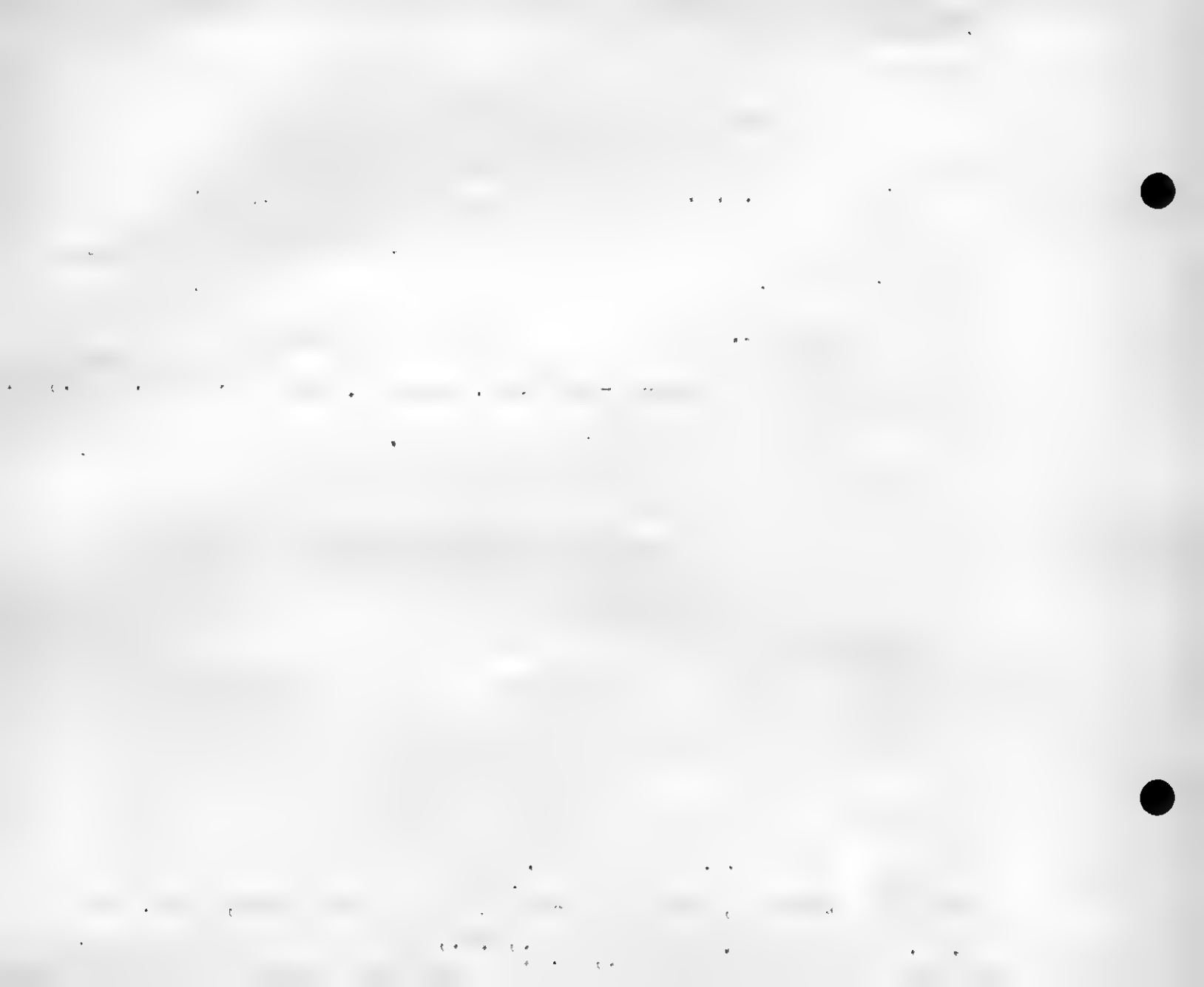
08853

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08847

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year			2b HOUR			
William			Paul			Lyle			6-6-69			11:00pm			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR	
Male		White		7-8-1909		59 YRS						6 Month 6 Day 69 Year		11:25pm	
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH			
Iowa				U.S.A.								Prince George's Md			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince George Hospital				Metal Lather				Construction			
13a USUAL RESIDENCE (Where deceased lived, if not in hospital give street address)				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland				Prince George's				Hillside				5544 Marlboro Pike			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME											
First Middle Last				First Middle Last											
William D. Lyke				Stella Rowland											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17 INFORMANT				ADDRESS			
Yes				WW II				578-03-1947				Mrs. Vivian N. Lyle 5544 Marlboro Pk., Dist. Hgts., Md.			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 6 mo.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No		City or Town		County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL EXAMINER'S NAME (Type)				22b DATE SIGNED											
John Kehoe M.D. Riverdale, Md.				6-8-69											
23a BURIAL OR CREMATION (Type)				23b DATE				23c NAME OF CEMETERY				23d LOCATION (City or Town) (County) (State)			
Burial				June 11, 1969				Cedar Hill Cemetery				Suitland, Maryland			
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REG STRAR				25b REGISTRAR'S SIGNATURE			
W. W. CHAMBERS CO., 517 11th St., S.E., Wash., D.C.								JUN 12 1969				[Signature]			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10340				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR		
Lawrence John Mack Sr									Month Day Year June 28 1969			? M		
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR		
M	W	5 Jan 1918		51 YRS					Month Day Year 7 6 1969			11:00 PM		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Minnesota			U S A						Prince George					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Bowie			Home			School teacher			Public school					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md.			Prince George Bowie			Bowie			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12525 Windover Turn		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
Joseph V Mack			Theresa Bunderle											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown <input type="checkbox"/>			474 01 2508			Maxine Mack			Bowie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____											min			
DUE TO, OR AS A CONSEQUENCE OF _____														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) _____														
DUE TO, OR AS A CONSEQUENCE OF _____														
(c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
				? 6 28 1969			Shot self at home with .22 cal rifle							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town				
				Bedroom of home			Same as # 13							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						7-6-69				
John Kehoe, M.D., Riverdale				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>										
				ADDRESS (Street, city, town, or county)										
23a. BURIAL OR CREMATION				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County) (State)			
Burial				July 9, 1969		Arlington National			Arlington		Virginia			
24. FUNERAL DIRECTOR				ADDRESS						25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE		
				F. Gasch's Sons Hyattsville, Md.						JUL 14 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) Warren W.			First Middle Last W. Mac Neill			2a DATE OF DEATH 6 Month 30 Day 69 Year		2b HOUR 12 40 M	
3 SEX M		4 RACE W		5. DATE OF BIRTH 9-28-85		6 AGE (In years last birthday) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS M N	
7a BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md			
1d CITY OR TOWN OF DEATH Clinton, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY PRINCE GEORGE'S		13c CITY OR TOWN Pap Springs		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7520 Mansfield Dr.	
14 FATHER'S NAME First Middle Last Charles Mac Neill			15 MOTHER'S M A DEN NAME First Middle Last Fannie Steptenson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown? (If yes give war or dates of service) No			16b SOCIAL SECURITY NO.		17 INFORMANT Address Hazel E MacNeill, wife				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1 DEATH CAUSED BY IMMEDIATE CAUSE (a) Circulatory Collapse									
4124 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary insufficiency									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Arteriosclerotic cardiovascular disease									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Biateral hip amputations + diabetes mellitus									
19a DATE OF OPERATION 6/4/69		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Circulatory insufficiency		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6/29 , 19 69 , to 6/29 , 19 69 , that (I) (we) lost saw the deceased alive on 6/29 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (d) (not) view the body after death.									
22b SIGNATURE Alfred R Lapin, MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 6/30/69			
22d PHYSICIAN'S NAME (Type) ALFRED R LAPIN, MD		22e ADDRESS CLINTON, MD							
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE 6/30/69		23c NAME OF CEMETERY OR CREMATORY Cedar Hill		23d LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home				25a REC'D BY REGISTRAR JUL 7 1969		25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and page 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08856

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08849

1. DECEASED-NAME (Type or print) MG George MAISEL			2a. DATE OF DEATH 6 Month 1 Day 69 Year		2b. HOUR 5:30 AM
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH 9-20-02	6 AGE (In years lost birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Datto Ind	7b. CITIZEN OF WHAT COUNTRY? US	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH PRINCE GEORGES Md.		
10 CITY OR TOWN OF DEATH Adelphi	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MANOR CARE	12a. USUAL OCCUPATION (Kind of work done or no most of working life, even if retired) General Assistant	12b. KIND OF BUSINESS OR INDUSTRY US Govt. Jern		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD	13b. COUNTY Howard	13c. CITY OR TOWN LAUREL	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 345 Highridge Rd	
14. FATHER'S NAME First Middle Last Fredrick L. Maisel	15. MOTHER'S MAIDEN NAME First Middle Last Esther Shumaker	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) no			
16b. SOCIAL SECURITY NO		17 INFORMANT Mrs Helen Maisel, Highridge Rd. Laurel, Md			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Disufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 5/3 , 19 69 , to 6/1 , 19 69 , that (I) (we) lost saw the deceased alive on 5/29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 6/6/69		
22d. PHYSICIAN'S NAME (Type) DR. Allan Cohen		22e. ADDRESS 13515 GEORGIA AVE - S-S MD			
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE 6-4-69	23c. NAME OF CEMETERY OR CREMATORY Emmanuel Cem	23d. LOCATION (City or Town) (County) (State) Scaggville Md.		
24. FUNERAL DIRECTOR Donaldson Funeral Home		ADDRESS Laurel Md	25a. REC'D BY REGISTRAR DATE JUN 10 1969	25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08857

CERTIFICATE OF DEATH

08850

1 DECEASED NAME (Type or print) JOHN M MCCARTHY			2a. DATE OF DEATH Month June Day 29 Year 1969			2b. HOUR 3:45P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 01-31-97		6. AGE (In years last birthday) 72 YRS.		
7a BIRTHPLACE (State or foreign country) Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY Prince George's		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last unknown			15 MOTHER'S M maiden name First Middle Last unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 233-10-2920		17. INFORMANT Ralph Parnell Address Seabrook, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ANTERIO-POSTERIOR DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 hrs								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIA BETES MELLITUS -								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from June , 19 65 to 6-29 , 19 69 , that (I) (we) last saw the deceased alive on 6-29 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Albert Roth, M.D.				22c. DATE SIGNED 6/30/69		22d. PHYSICIAN'S NAME (Type) Albert Roth, M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/2/69		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor Fr. Soc. MD.		
24. FUNERAL DIRECTOR W. N. Chambers Co., Riverdale, Md.				25a. REC'D BY REGISTRAR JUL 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

**FOR STATE
HEALTH DEPT.**

08855

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

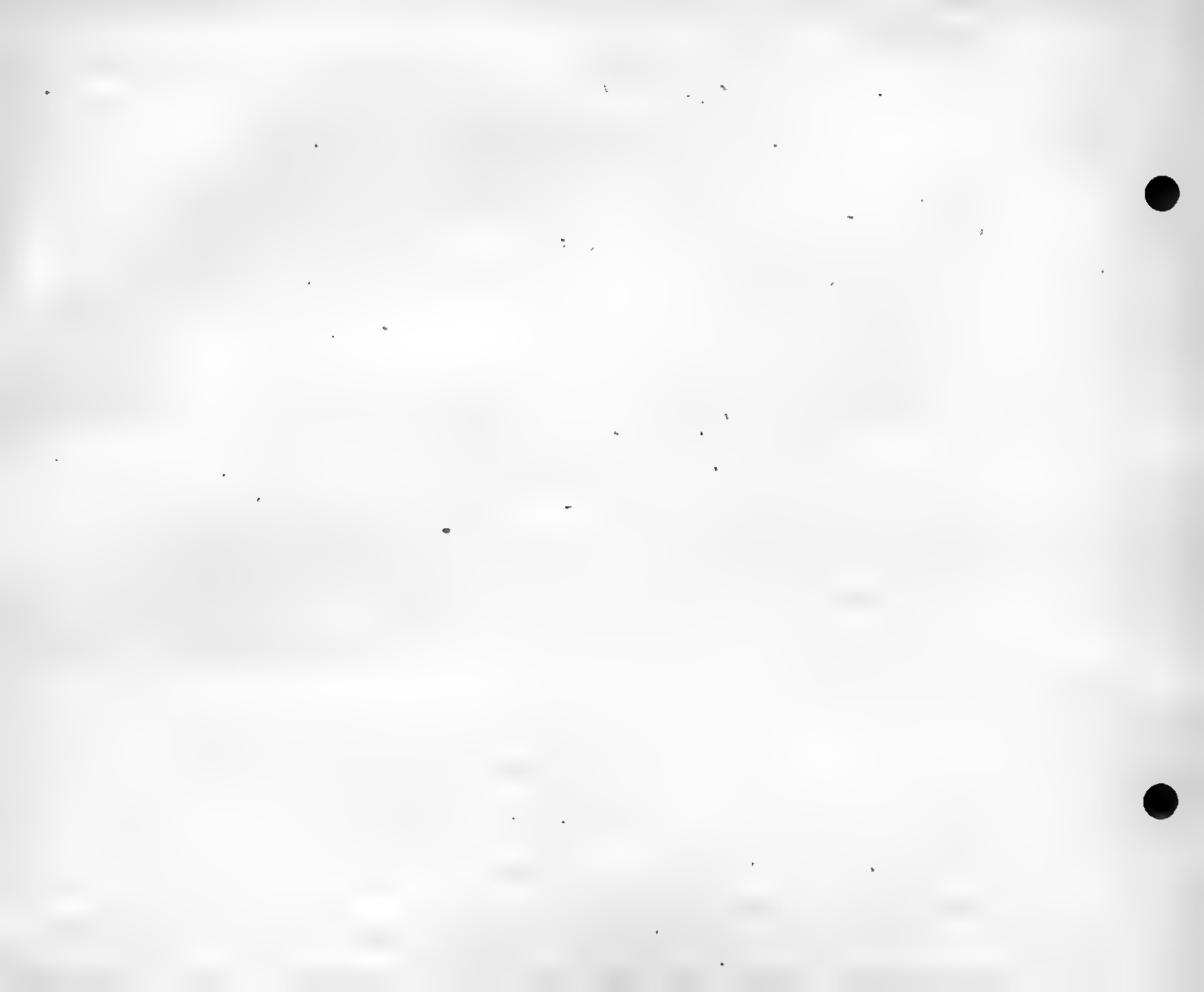
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08851

1. DECEASED-NAME (Type or Print) Robert LEE MITCHELL			2a. DATE KNOWN OF EST DEATH <input type="checkbox"/> June 21 1969 18 M			2b. HOUR 18 M		
3 SEX M	4 RACE N	5 DATE OF BIRTH 4-4-20	6 AGE (In years last birthday) 49 YRS	IF UNDER 1 YEAR MONTHS 4 DAYS 1	IF UNDER 24 HRS HOURS 1 MIN. 57	2c. DATE PRONOUNCED DEAD Month June Day 21 Year 1969 18 M		
7a. BIRTH PLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges Md		
10. CITY OR TOWN OF DEATH Chesley		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Brick Layer		12b. KIND OF BUSINESS OR INDUSTRY Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE DC 13b. COUNTY WASHINGTON			13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 20 Bate St NW	
14. FATHER'S NAME First Willie Middle Lee Last I			15. MOTHER'S MAIDEN NAME First MINNIE Middle GREEN Last GREEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS CARRIE MITCHELL - wife - Same			
18. CAUSE OF DEATH (Enter any one cause or combination of (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Wounds multiple & severe 8199 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Confusion + laceration of Brain Fracture Skull - Auto accident DUE TO OR AS A CONSEQUENCE OF (b) Fracture Skull - Auto accident DUE TO OR AS A CONSEQUENCE OF (c) Fracture Skull - Auto accident								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dayton O. Watkins M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 6-22-69		
EXAMINER'S NAME (Type) DAYTON O. WATKINS			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-30-69		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City or Town) 7601 Sheriff Rd (County) Landover (State) Md		
24. FUNERAL DIRECTOR ADDRESS Washington Fun Chapel 475-H St NW				25a. REG. BY REGISTRAR JUN 30 1969		25b. REG. BY REGISTRAR JUN 30 1969		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

08859

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08852

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 6-10-69 19 8:00am				2b HOUR			
Lee		Jacob		Moore											
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD Month Day Year 6 10 69 19 7:01am				2d HOUR		
Male	White	8-5-1907		61 YRS											
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.							
Illinois		USA				Prince George's									
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince George Hospital				Manager				Hwd Storex			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)- STATE				13b COUNTY				13c CITY OR TOWN		13d INSIDE CITY, M 15?		13e STREET AND NUMBER			
Maryland				Prince George's				Landover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5301 85th. Ave. #201			
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
unknown								unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17 INFORMANT							
no				no				578-05-9231 Mr. John A. Goldstone, Son, Springfield, Va.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure												minutes			
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease												over 9 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
				HOUR A.M. P.M. 19											
21d INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				2 f. LOCATION Street or R.F.D. No City or Town County State							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>															
22a I certify that took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED			
John Kehoe				John Kehoe M.D. Riverdale, Md.				ADDRESS (Street, city, town, or county)				6-10-69			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)					
Burial				June 13, 1969		Resurrection Cemetery				Clinton Prince Georges Md.					
24 FUNERAL DIRECTOR				25a REGISTRY				25b REGISTRAR'S SIGNATURE							
Lanham Funeral Home				Robert S. Beaulieu				JUN 12 1969				Judge			
Lanham, Maryland 20801				DATE											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1594

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A16
45M

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR				
Cora			MARY MORAN			June 2 1969			M				
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS		
Fem.		Cau.		Dec 11 1889			19 YRS		5 MONTHS 11 DAYS		Mm		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Dobara Md			U.S.						Prince George's Co			Md.	
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Clinton, Md				Fine View Gardens				Housewife				DOMESTIC	
13a USUAL RESIDENCE (Where deceased lived or institution, Residence before admission) STATE				13b CITY OR TOWN				13c INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Undersdorf Md				Charles Maryland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Rt 2 212A			
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last									
George W. Moran				Cora M Moran									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b SOCIAL SECURITY NO				17 INFORMANT Address					
No				213-24-3924				Mary C. Edelen (dau.) Undersdorf Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac & Circulatory Collapse 10 min													
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma 6 mos.													
DUE TO, OR AS A CONSEQUENCE OF (c) Gastrointestinal malignancy 1 1/2 yrs													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) rectal-vaginal fistula													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)							
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No			City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from 3-12-1967 to 6-2-1969, that (I) (we) lost saw the deceased alive on 6-2-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE Alfred R. Lapin, M.D.						22c DATE SIGNED 6-2-69							
22d PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD						22e ADDRESS CLINTON, MD							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			June 5 1969			St. Mary's			Bryantown, Md.				
24 FUNERAL DIRECTOR The Hunt Funeral Home, Undersdorf, Md						25a REC'D BY REGISTRAR JUN 9 1969			25b REGISTRAR'S SIGNATURE				

FOR STATE HEALTH DEPT.

any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-2. **Page 5 may be retained for your files.**
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08861 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08854							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b HOUR					
Ronald			Thoedore		Morosko					6-24-69		19 1:08am					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR					
Male		White		1-3-1947		22 YRS				6 Day 24 Year 69		19 2:18am					
7a BIRTHPLACE (State or foreign country)			7b CIT ZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md					
West Va			U.S.A.						Prince George's								
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY					
Cheverly				Prince George Hospital				Programmer									
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission), STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER							
District Of Columbia				Washington						825 New Hampshire Ave NW							
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last	
Theodore			Morisko						Shirley			Garvin					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO. (If yes give war or dates of service)			17 INFORMANT			ADDRESS			2215 31st St S.E. Wash, D.C.					
			577 64 5279			Theodore Morosko											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock																	
DUE TO, OR AS A CONSEQUENCE OF Multiple fractures, - Pelvis,																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
(b) Sternum and both legs.																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. 1:05am 6-24- 19 69				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of car which struck bridge abutment									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. 301 near McKendree Dr., Brandywine, Prince George County, Md.		21f LOCATION Street or RFD No		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED 6-24-69					
23a BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)									
Burial		6-27-1969		Cedar Hill				Suitland Pr. Co Md									
24 FUNERAL DIRECTOR Robert A. Mattingly				ADDRESS 131 11th St S.E. Wash D.C.				25a RECD BY REG STRAR		25b REGISTRAR'S SIGNATURE V. Charles Judge							
								JUN 30 1969									



08862

CERTIFICATE OF DEATH

08855

1. DECEASED NAME (Type or print) First Middle Last Ellsworth D. Muller			2a. DATE OF DEATH Month Day Year 6 18 69			2b. HOUR 1 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-01-10		6. AGE (In years lost birthday) 58 YRS.	
7a. BIRTHPLACE (State or foreign country) Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) City Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY V.A. Admin	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7542		13f. CITY OR TOWN Clinton		13g. STATE MD		13h. ZIP CODE 21115	
14. FATHER'S NAME First Middle Last Charles F. Muller			15. MOTHER'S MAIDEN NAME First Middle Last Alice Muller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 577 10 304		17. INFORMANT Anna M. Muller (same as 13d)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) diabetes mellitus; Polymyositis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 68 to June 18 , 19 69 that (I) (we) last saw the deceased alive on June 7 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Don B. Cameron				22c. DATE SIGNED 6-18-69		22d. PHYSICIAN'S NAME (Type) DON B. CAMERON	
22e. ADDRESS 3503 PERRY ST		22f. CITY OR TOWN MIDDLEBURY, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-21-1969		23c. NAME OF CEMETERY OR CREMATORY Fair Lincoln		23d. LOCATION (City or Town) (County) (State) Prince George County MD	
24. FUNERAL DIRECTOR Muller 131-11th St. S.E.		25a. REC'D BY REGISTRAR JUN 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



7769

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08863

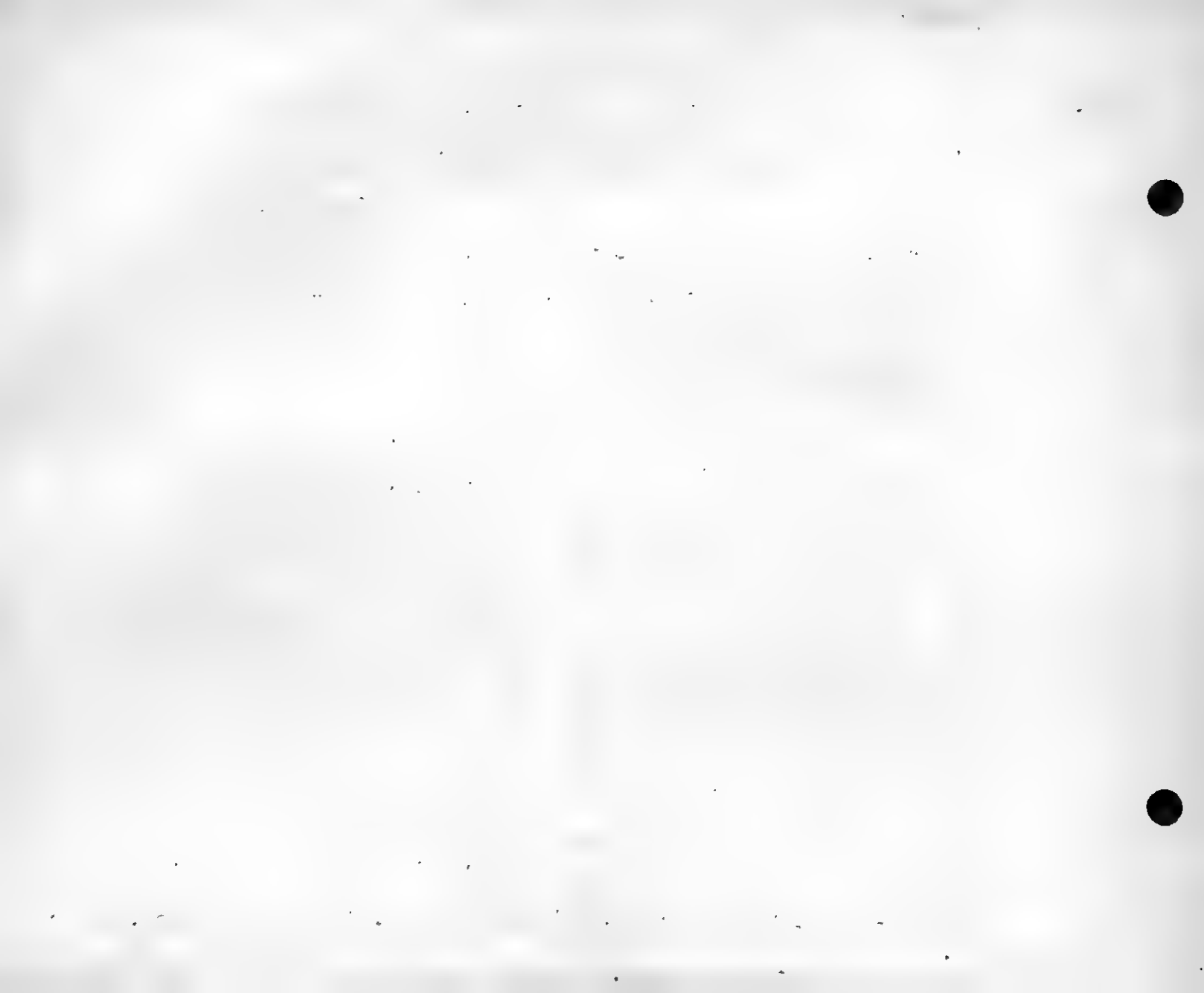
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08856

Item #14,15, Taken from birth certificate

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Baby Girl Murray			2a. DATE OF DEATH Month Day Year June 9, 1969			2b. HOUR 4 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 06-09-69		6. AGE (In years last birthday) YRS. MONTHS DAYS HOURS MIN 2 30	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN College Pk.		13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 4907 Osage Street		14. FATHER'S NAME First Middle Last Guy Paul Murray		15. MOTHER'S MAIDEN NAME First Middle Last Louise Olive Winebrenner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, na, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. col. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-9-69</u> , to <u>6-9-69</u> , that (I) (we) last saw the deceased alive on <u>6-9-69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John Perkins</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6-9-69</u>	
22d. PHYSICIAN'S NAME (Type) John Perkins				22e. ADDRESS 6201 Riverdale Rd. Riverdale MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 6-14-69		23c. NAME OF CEMETERY OR CREMATORY Pr. George's General Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly, Pr. George's, Md.	
24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr.</u>				ADDRESS Administrator		25a. REC'D BY REGISTRAR JUN 19 1969	
				25b. REGISTRAR'S SIGNATURE <u>Richard J. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
Margaret			G.		Murray				Month Day Year		
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7b. HOUR		
Female			White		01-20-33		36 YRS		6:40 PM		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Pa.			U.S.A.				Prince Georges County		MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Georges Gen. Hosp.			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, W. 15?		13e. STREET AND NUMBER		
Maryland			Prince Georges		Greenbelt		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21 Woodland Way		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Harry			R.		Gibson				Margaret L. Lundy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address				
no			118 26 8622		Joseph C. Murray		Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic infarctions of lungs											
7463 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Hemorrhage interventricular septum of heart											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Ulcerative colitis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 1969, to June 7, 1969, that (I) (we) last saw the deceased alive on June 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and) (not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
W. C. Weintraub			Prof. Bldg. 115 Centerway Greenbelt, Md								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			6/10/69		Arlington National		Arlington		Va.		
24. FUNERAL DIRECTOR			ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Francis Gasch's Sons			Hyattsville, Md.		JUN 13 1969		W. C. Weintraub				

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08865						08858					
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
ANNIE F Nelson						June Month 13 Day 69 Year			945 P. M.		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR		IF UNDER 1 YRS.	
Female		White		Sept 25, 1878		90 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
IRELAND			U.S.A.						Prince George's Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
HYATTSVILLE			HYATTSVILLE N.H. 6500 R. 993 Rd.			H. Wife			Home		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
D.C.			D.C.			WASH.			501 Oneida Pl N.W.		
14 FATHER'S NAME First Middle Last			5. MOTHER'S MAIDEN NAME First Middle Last								
FRANK Spenson			MARY ANN COONEY								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT Address					
						Mrs Mary Beard, 501 Oneida Place N.W.					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, terminal</u>										3 weeks	
43771 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis, general</u>										years	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (c) <u>Cerebral arteriosclerosis (senility)</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 1957 to June 13, 1969, that (I) (we) lost saw the deceased alive on June 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>John F. Brennan Jr. M.D.</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED June 13, 1969		
22d. PHYSICIAN'S NAME (Type) John Brennan, Jr. M.D.						22e ADDRESS 3415 Hamilton St. Hyattsville, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			6/17/69			Arlington National Cem			Arlington Va.		
24 FUNERAL DIRECTOR: W. K. Hunterman & Son, ADDRESS 5732 Georgia N.W. D.C.						25a REC'D BY REGISTRAR JUN 17 1969			25b REGISTRAR'S SIGNATURE		

1621

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, name should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 2 Film 414 7-2-64 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 08866 CERTIFICATE OF DEATH 08859													
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S HOSPITAL MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY PRINCE GEORGES -- HILLSIDE, MD.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY, MARYLAND				c. LENGTH OF STAY IN 1b 1 MONTH		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE'S HOSPITAL						d. STREET ADDRESS 1208 6th St. N.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last NOLAN			4. DATE OF DEATH Month JUNE Day 2 Year 1969			5. SEX MALE			6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH SEPT. 29, 1906			9. AGE (In years last birthday) 62 yrs.			IF UNDER 1 YEAR Months 6 Days 19 Mln. 69		IF UNDER 24 HRS. Months 6 Days 19 Mln. 69					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN						14. MOTHER'S MAIDEN NAME UNKNOWN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. BARBARA J. ARMSTEAD - DAUGHTER				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma c metastases 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 15 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from march , 19 68 , to June 2 , 19 68 , that (I) (we) last saw the deceased alive on May 28 19 69 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.													
22a. SIGNATURE Louis H. Shuman						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 3, 1969					
22c. PHYSICIAN'S NAME (Type) Louis H. Shuman, M.D.						22d. ADDRESS 1635 Massachusetts Ave. N.W. Wash. D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6-7-69		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park			23d. LOCATION (City, town or county) (State) Prince George, Maryland					
24. FUNERAL DIRECTOR John T. Rhines Company Funeral Home 3015 21th Street, N/ E., Washington, D. C.						25a. REC'D BY REGISTRAR JUN 9 1969		25b. REGISTRAR'S SIGNATURE William Judge					



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08867		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08860	
Item 13 Film 414 7/14/69 kk							
1. DECEASED NAME (Type or print) A. Eileen			First Middle Last O' Brien			2a. DATE OF DEATH 6 Month 29 Day 69 Year	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH 6-23-1886		6 AGE (In years last birthday) 83 YRS	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Reg. Nurse		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USLA. RESIDENCE (Where deceased lived, if institution: Residence before address an) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME JOSEPH		First Middle Last O'Brien		15. MOTHER'S MAIDEN NAME MARY Ann BERRY		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) Yes		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 212-40-0871		17. INFORMANT U Connor, RN 2103 Guilford Rd., Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) PNEUMONITIS, RIGHT LOWER LOBE							
DUE TO, OR AS A CONSEQUENCE OF							
(b) CULTURES PENDING							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
GENERALIZED ARTERIOSCLEROSIS; SEVERE OSTEOARTHRITIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MAY 1, 1968 , to JUNE 29, 1969 , that (I) (we) lost saw the deceased alive on JUNE 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edith J. ... M.D.		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/29/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS MEDICAL ARTS BUILDING 6480 NEW HAMPSHIRE AV. TAKOMA PARK, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-2-69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cen		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR James E. DeVal		ADDRESS 2222 W. ... N.W.		25a. REC'D BY REGISTRAR JUL 7 1969		25b. REGISTRAR'S SIGNATURE Charles ...	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17-3-69 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08863

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08861

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
Bruce		S		Odesser	6-11-69		19	2	30pm	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day	Year
Male	White	6-5-1939	30 YRS	MONTHS	DAYS	6		11	69	192:30pm M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED	NEVER MARRIED	9. COUNTY OF DEATH				
BRONX N.Y.		U.S.A.		WIDOWED	DIVORCED	Prince George's		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address)		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince George Hospital		ACCOUNTANT						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland		Anne Arundel		Crofton		YES <input type="checkbox"/> NO <input type="checkbox"/>		1718 Tipton Drive		
14. FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
MURRAY		Odesser		YETTA	KATZ					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS				
Yes		1515-1968 085-30-0645		William Recree		9921-Blindbrook		Lanham, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Laceration of brain										
DUE TO, OR AS A CONSEQUENCE OF Trauma - auto accident										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d. LOCATION Street or R.F.D. No				
CAUSE OF DEATH		7:28am 6-11-1969		Driver of car which went out of control and overturned		City or Town				
21a INJURY OCCURRED		21b PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21c. LOCATION Street or R.F.D. No		City or Town		County		State
WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		Southbound lane Rt. 3 near Bel Air Dr., Prince George County, Md.								
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b DATE SIGNED		
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				6-12-69		
John Kehoe MD Riverdale, Md.				DEPUTY MEDICAL EXAMINER						
ADDRESS (Street, city, town, or county)										
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		6-13-1969		MT. HERBERT CEM		FARMINGDALE				N.Y.
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
BERNARD DANZANSKY		Sims Washington D.C.		JUN 16 1969		R. C. ...				

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08869

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08862

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR																	
Raymond James Oliver						6-28-69			12:32am			M																	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR															
Male		White		6-24-1946		23 YRS		MONTHS DAYS		HOURS MIN		6 Month 28 Day 69 Year		1:57am M															
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																	
Washington, D.C.				U S A								Prince George's Md.																	
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b. KIND OF BUSINESS OR INDUSTRY											
Cheverly						Prince George Hospital						Fabric Hanger																	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS?						13e. STREET AND NUMBER					
Maryland						Prince George's						Lanham						YES <input type="checkbox"/> NO <input type="checkbox"/>						8619 Defense Highway					
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																							
Alvin Oliver						Marjorie Van Heiten																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO						17. INFORMANT						ADDRESS											
No												Mrs. Nancy J. Oliver, Same as 13 E.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain																													
8160 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last																													
(b) DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?																	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or over returned.)																					
				1:30am 6-28-1969				Driver of car which went out of control and																					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No				City or Town				County				State									
				Rt. 495m 1 mile so. of				Rt. 218, Largo, Prince George County, Md.																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED																	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						6-29-69																	
John Kehoe MD Riverdale, Md.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																							
ADDRESS (Street, city, town, or county)																													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)																	
Burial				7/1/69				Resurrection Cemetery				Clinton, Md.																	
24. FUNERAL DIRECTOR								25a. REC'D BY REGISTRAR								25b. REGISTRAR'S SIGNATURE													
Robert E. Wilhelm Funeral Home								JUL 7 1969								Charles Judge													
4308-Suitland, Rd. Suitland, Md.																													

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08870

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08864

1 DECEASED NAME (Type or Print) EDWIN CHARLES ORNDORFF						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH June DAY 21 YEAR 1969		2b. HOUR 4 MIN 15		
3 SEX M	4 RACE W	5 DATE OF BIRTH 11-18-24	6 AGE (in years last birthday) 44 YRS	7 UNDER YEAR MONTHS 0 DAYS 0	8 UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD MONTH June DAY 21 YEAR 1969		2d. HOUR 4 MIN 15		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.				
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince Georges General Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY Curtis and		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b. COUNTY Pr		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1905 Brooks Rd Apt 202	
14. FATHER'S NAME First unknown Middle Last 				15. MOTHER'S MAIDEN NAME First Elizabeth Middle Cissel Last 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give year or dates of service) WW2				16b. SOCIAL SECURITY NO. 111-11-1111		17. INFORMANT Son		ADDRESS 1905 Brooks Rd Beltsville Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF few minute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOJR A.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. 		City or Town 		County State 		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Dayton D Watkins M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) DAYTON D WATKINS				ADDRESS (Street, city, town, or county) 		22b. DATE SIGNED 6-21-69				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/24/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland, Md.		(County) (State)		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308-Suitland, Rd. Suitland, Md.						25a. REC'D BY REGISTRAR JUN 25 1969		25b. REGISTRAR'S SIGNATURE Judge		

FOR STATE HEALTH DEPT.

17822a File # 415 7-31-69
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08871

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08865

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
Madge Elaine Payne						6-1-69			197:35am						
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female		White		22 Feb 1924		45 YRS						6 1 69		1910:25am	
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH			
Pennsylvania				U. S. A.								Prince George's Md			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince George Hospital				Clerk				Dry Cleaning Company			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution - State)				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Maryland				Prince George's				Hyattsville				YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Clarence S. Farliegh				Mary E. Snyder											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
Seaman 1st				1944-1946				168 18 9316				John T. Payne Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA & CONGESTION</u>															
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary edema & congestion</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Etiology undetermined</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
MEDICAL CERTIFICATION															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on death resulted from. Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type) John Kehoe MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				6-2-69							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
				ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY							
Burial				6/4/69				Ft. Lincoln							
								23d. LOCATION (City or Town) (County) (State)							
								Colmar Manor P.G. Md.							
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Francis Gasch's Sons Hyattsville, Md.				JUN 6 1969				Francis Gasch							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08872

08866

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR							
Carl		H		Peck				6-29-69		195		25am											
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year							
Male	White	9-2-1912		56 YRS		MONTHS		DAYS		6		29		69		5:25am							
7a. BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH								Md							
Vermont		U S A.		WIDOWED		DIVORCED		Prince George's															
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY																	
Chesley		Prince George Hospital		Salesman																			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER																	
Maryland		Prince George's Bradbury Hgts		YES		NO		5122 Byers Street															
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last									
Edward		Peck						Ethel		Tower													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS																	
Yes. Pecketime		008.10.2559		Daisy G. Peck.		same as 13e																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of brain																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																							
DUE TO, OR AS A CONSEQUENCE OF																							
DUE TO, OR AS A CONSEQUENCE OF																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?											
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)															
				3:00am 6-29-1969				Shot self at home															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town				County				State			
				Home				Same as #13															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>																							
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				John Kehoe MD				Riverdale, Md.				22b. DATE SIGNED							
																6-30-69							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)				(County)				(State)			
Burial				7.5.69				Ascutney Cemetery				Windsor.				Vermont							
24. FUNERAL DIRECTOR				ADDRESS				Wash. D.C.				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Lee Funeral Home. 300.4th st N E												JUL 7 1969				J Charles Judge							

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08873

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08867

CERTIFICATE OF DEATH

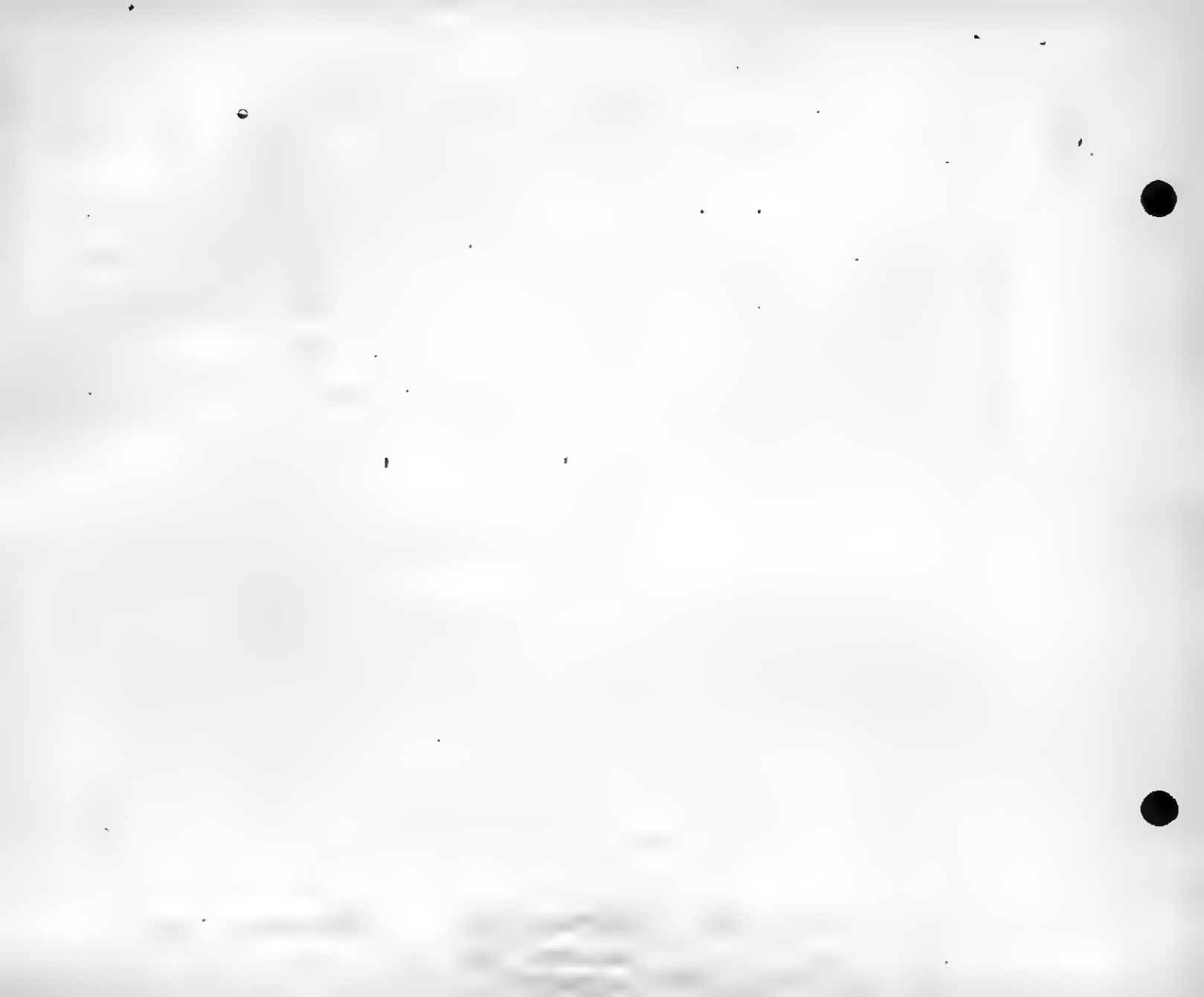
1. DECEASED-NAME (Type or print) FRANCISCO First Middle Last			2a. DATE OF DEATH Month JUNE Day 12 Year 1969 2b. HOUR 3A		
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MARCH 20, 1900	
7a BIRTHPLACE (State or foreign country) CUBA		7b CITIZEN OF WHAT COUNTRY? CUBA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH CHEVERLY		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PRINCE GEORGES GEN		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CHADOFFEUR	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY PRINCE GEORGES		13c CITY OR TOWN COLLIDGE PK	
4 FATHER'S NAME First MANUEL Middle PENA Last CARLOTA		15 MOTHER'S MAIDEN NAME First ARANCEI Middle ARANCEI Last ARANCEI		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)	
16b SOCIAL SECURITY NO NONE		17 INFORMANT MRS AIDE ALVAREZ Address 1606 N ADAMS ST ARL, VA.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary insufficiency. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) carcinoma metastasis of the lung. DUE TO, OR AS A CONSEQUENCE OF (c) Hepatoma.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from SEPT 20, 1968 , to JUNE 10, 1969 , that (I) (we) last saw the deceased alive on JUNE 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rafael C. Inclan M.D.				22c. DATE SIGNED June 13, 1969	
22d. PHYSICIAN'S NAME (Type) RAFAEL C. INCLAN				22e. ADDRESS 3308 Dodge Park Rd. Md 20785	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE JUNE 14, 1969		23c NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL	
23d LOCATION (City or Town) (County) (State) SWITLAND, MARYLAND		23e. REC'D BY REGISTRAR W.W. CHAMBERS CO. RIVERDALE, MD		23f REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08874 CERTIFICATE OF DEATH 08868										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Eugene J. Plummer						Month Day Year 06 17 69		8:15 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Negro		05-28-07		68 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Prince Georges County, Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			Eugene Leland Mem. Hosp.			Unemployed		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before death)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince Georges		Brentwood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4526 40th Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Holloman			Plummer			Susie Orr				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
					Address Milton C. Plummer, Son, 1301 Saratoga Av., NE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>stroke aneurysm atherosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>rupture of aorta</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>emphysema</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
6-17-69		Abdominal			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 6-17-69, to 6-17-69, that (I) (we) last saw the deceased alive on 6-17-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)								6-18-69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6-23-69		Harmony		Londonderry Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Rivers Funeral Home		305 North Ave		JUN 26 1969		Rivers				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08875									
CERTIFICATE OF DEATH									
08869									
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH	
Elizabeth						Popham		Month Day Year 6 7 69 5:30 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
F		W		4-14-1889		80 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH		10	
VA.		U.S.A.		NEVER MARRIED		Prince George		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13	
Clinton		Pineview Garden		Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.		V		Charles Rockpoint		YES NO			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
JAY						Hudson		Elizabeth GARD	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address		18	
Yes () No ()									
18		19		20		21		22	
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743		744		745		746		747	
748		749		750		751		752	
753		754		755		756		757	
758		759		760		761		762	
763		764		765		766		767	
768		769		770		771		772	
773		774		775		776		777	
778		779		780		781		782	
783		784		785		786		787	
788		789		790		791		792	
793		794		795		796		797	
798		799		800		801		802	
803		804		805		806		807	
808		809		810		811		812	
813		814		815		816		817	
818		819		820		821		822	
823		824		825		826		827	
828		829		830		831		832	
833		834		835		836		837	
838		839		840		841		842	
843		844		845		846		847	
848		849		850		851		852	
853		854		855		856		857	
858		859		860		861		862	
863		864		865		866		867	
868		869		870		871		872	
873		874		875		876		877	
878		879		880		881		882	
883		884		885		886		887	
888		889		890		891		892	
893		894		895		896		897	
898		899		900		901		902	
903		904		905		906		907	
908		909		910		911		912	
913		914		915		916		917	
918		919		920		921		922	
923		924		925		926		927	
928		929		930		931		932	
933		934		935		936		937	
938		939		940		941		942	
943		944		945		946		947	
948		949		950		951		952	
953		954		955		956		957	
958		959		960		961		962	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08876

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08870

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b HOUR		
Ronald Henry Pounsberry						6-24-69 1912:30pm					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS.	2c DATE PRONOUNCED DEAD			2d HOUR		
Male	White	1-27-1902	67 YRS.	MONTHS	DAYS	6 Month 24 Day 69 Year 1912:30pm					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
England			U. S. A.			Prince George's			Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Cattle Dealer			Own Business		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Prince George's			Upper Marlboro			Box 2256		
14 FATHER'S NAME			15 MOTHER'S MA DEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		
Henry			-- Pounsberry			--			220-3436-43A		
17 INFORMANT			18 ADDRESS			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Mrs. Rose Irene Pounsberry			Box 2256								
Upper Marlboro			Md.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Occlusion of right coronary artery											
4109 DUE TO, OR AS A CONSEQUENCE OF Hemorrhage into atherosclerotic plaque											
(b) From Arteriosclerotic heart disease											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Lymphocytic leukemia - over 1 month											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL EXAMINER'S NAME (Type)			22b. DATE SIGNED			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		
John Kehoe MD			6-24-69			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
Riverdale, Md.											
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			6/27/69			Addison's Chapel Cem:			Seat Pleasant Pr. Geo., Md.		
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Ritchie Bros. Upper Marlboro, Md. 20870			DATE JUL 7 1969			Charles Judge					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-100. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08877

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08873

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR					
John Wesley Powell						25 6 13			19 69			7:10 P.M.					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR						
M	W	15 Aug 1888	80 YRS	MONTHS DAYS		HOURS MIN		Month 6 Day 13 Year 19 69			7:40 P.M.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.					
Vermont			U. S. A.						Prince George								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Cheverly			Prince George Hosp														
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY - APTS?			13e. STREET AND NUMBER					
Md			Prince George Brentwood			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						3928 Allison St.					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
First Middle Last			First Middle Last														
James Powell			Mary (Unknown)														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
						Christine Powell			3928 Allison St.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a)												Metastatic carcinoma					
DUE TO, OR AS A CONSEQUENCE OF																	
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause												Bronchiogenic carcinoma					
(b)												over 10 mos					
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)									
				HOUR A.M. P.M. 19													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED									
EXAMINER'S NAME (Type)				John Kehoe, M.D., Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				6-14-69					
				ADDRESS (Street, city, town, or county)													
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
				6/19/69				Arlington Mt.				Arlington, Va					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Frazier 389 B.I. on NW								DATE JUN 19 1969				J. Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

450X

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Rose			E.	Powell	June 12 1969			6:50P	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER: YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
Female		Negro		03-07-01		68 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PA.		U.S.A.				Prince George's Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George's Gen. Hosp				Shopwoman			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		Prince George		Landover		YES <input type="checkbox"/> NO <input type="checkbox"/>		1925 Belle Haven Dr.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last			
John			Driffin			Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
					Melva Edwards Sammons 13 E				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive cerebral infarction, right</u>									
4339 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Pulmonary emboly, left</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Pulmonary edema</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Ca of Pancreas with metastasis to liver - old age</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that XX (this hospital) attended the deceased from <u>May 19</u> , 19 <u>69</u> , to <u>June 13</u> , 1969, that XX (we) last saw the deceased alive on <u>June 13</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (d d not) view the body after death.									
22b. SIGNATURE <u>P. C. Xavier</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/13/69		
22d. PHYSICIAN'S NAME (Type) <u>P. C. Xavier, M.D.</u>					22e. ADDRESS <u>Prince George's General Hospital</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>6-18-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosevelt Cemetery</u>		23d. LOCATION (City or Town) <u>Norfolk, Va.</u>		(County) (State)	
24. FUNERAL DIRECTOR ADDRESS <u>U.S. Washingtonians 4925 Penn Ave NE</u>					25a. RECEIVED BY REGISTRAR DATE <u>JUN 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08879

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08873

1 DECEASED-NAME (Type or print) <u>William</u>		First <u>William</u> Middle <u>Prout</u> Last <u>Prout</u>		2a. DATE OF DEATH <u>Jun 6</u> Month <u>27</u> Day <u>19</u> Year		2b. HOUR <u>6:15</u> AM	
3 SEX <u>M</u>		4 RACE <u>Negro</u>		5. DATE OF BIRTH <u>8-26-91</u>		6. AGE (in years last birthday) <u>77</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George's</u> Md.	
10. CITY OR TOWN OF DEATH <u>CHEVERLY, Md</u>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Prince Georges Gen. Hosp Police clinic</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u></u>		12b. KIND OF BUSINESS OR INDUSTRY <u></u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>Prince Georges</u>		13c. CITY OR TOWN <u>Bowie</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>John H.</u> Middle <u>Prout</u> Last <u>Prout</u>		15. MOTHER'S MAIDEN NAME First <u>Elizabeth</u> Middle <u>Queen</u> Last <u>Queen</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>Yes, no, or unknown</u>			
16b. SOCIAL SECURITY NO <u></u>		17. INFORMANT <u>Sean P. Trimble - daughter - 13106-11131</u>		Address <u>Bowie, Md.</u>			
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY <u>217</u> IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. no City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u></u> , 19 <u></u> , to <u></u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u></u> , 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>D. S. Bannan M.D.</u>				22c. DATE SIGNED <u></u>		22d. PHYSICIAN'S NAME (Type) <u></u>	
22e. ADDRESS <u></u>				22f. ADDRESS <u></u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/12/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ascension Catholic Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Bowie, Maryland</u>	
24. FUNERAL DIRECTOR <u>John T. Stewart, Jr.</u>				25a. REC'D BY REGISTRAR <u>JUL 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u></u>	
26. FUNERAL HOME <u>Stewart Funeral Home - 4001 Benning Road, N.E.</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08880

08874

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>13 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>— Guidance —</u>		e. STREET ADDRESS <u>7404 Aspen Ave</u>	
3 NAME OF DECEASED (Type or print) <u>JENNIE ELIZ. QUACKENBUSH</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1969</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1, 1872</u>
9. AGE (In years last birthday) <u>97</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>24</u> Hours <u>19</u> Min <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BROOKLYN, N.Y., USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Andrew Brown</u>		14. MOTHER'S MAIDEN NAME <u>Hall</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>44-3888-1000</u>	
17 INFORMANT <u>Ed Russell Quackenbush ne - Takoma</u>		Address <u>7424 Aspen</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4124 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ pm _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>7:56 PM</u> to <u>June 24, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 24, 1969</u> , and that death occurred at <u>5:20 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>James M. Whitlock</u>		22b. DATE SIGNED <u>June 24, 1969</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>		22d. ADDRESS <u>2717 Cambridge Takoma Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 27 - 1968</u>	23b. DATE THEREOF <u>June 27 - 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington High Rd. P. Box 711</u>	23d. LOCATION (City or town) (County) (State) <u>Th</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>254 Carroll St</u>	25b. REGISTRAR'S SIGNATURE <u>James M. Whitlock</u>
DATE <u>JUN 27 1969</u>		DATE <u>JUN 27 1969</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08881

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08875

1. DECEASED NAME (Type or print) First Middle Last Mary A. Quinn			2a. DATE OF DEATH Month Day Year June 30 1969		2b. HOUR 11:35 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 7/4/1888		6. AGE (In years last birthday) 80 YRS	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Pr. Geo.		
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY OWN Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD	13b. COUNTY Prince George's	13c. CITY OR TOWN Mt. Rainier	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2506 Queens Chapel Rd.	
14. FATHER'S NAME First Middle Last John MC Grane	15. MOTHER'S MAIDEN NAME First Middle Last Mary Tracy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO 196-01-6778-B	17. INFORMANT Hospital Records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema, acute 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from June 27, 1969 to June 30, 1969 , that (I) (we) last saw the deceased alive on June 27, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE J. A. Voss		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) J. A. Voss		22e. ADDRESS 3701 Mac. Ave. A.W. Wash		22d. DATE SIGNED July 1, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 4, 1969	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Hanover Township, Wilkesbarre, Penn.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Nalley's Funeral Home		ADDRESS Mt. Rainier, Md.		25a. RECEIVED BY REGISTRAR JUL 7 1969	25b. REGISTRAR'S SIGNATURE Charles Judge

08882

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08876

1 DECEASED-NAME (Type or print) Eva B. Randall			2a. DATE OF DEATH 6 Month 7 Day 69 Year			2b. HOUR 6:45 PM			
3 SEX female		4 RACE white		5 DATE OF BIRTH 10/15/93		6 AGE (In years last birthday) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10 CITY OR TOWN OF DEATH Riverdale		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) homemaker		12b KIND OF BUSINESS OR INDUSTRY			
13a USUA. RESIDENCE (Where deceased lived, if institution residence before address only) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Lanham		3a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 9221 Alcona Street	
14. FATHER'S NAME First Middle Last John Abell			15 MOTHER'S MAIDEN NAME First Middle Last Mary						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Evelyn Griffith 5308 Wilkens Dr Camp Springs Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intractable CHF 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCD i atrial fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 8/7 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John Abell, M.D.					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-11-1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland PG Maryland		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland					25a. REC'D BY REGISTRAR DATE JUN 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 415 MARYLAND STATE DEPARTMENT OF HEALTH
7-31-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08877

1. DECEASED NAME (Type or Print) Victor Andrew Randall		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-23-69 19 1:00pm		2b. HOUR
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 12-15-1921	6. AGE (in years last birthday) 47 YRS	7c. DATE PRONOUNCED DEAD Month 6 Day 23 Year 69 8:22pm
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George Hospital		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Prince George's
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before) pdm ssian) STATE Maryland		13b. COUNTY Prince George's		13c. ASHORE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME Victor L. Randall, Sr.		15. MOTHER'S MAIDEN NAME Frances		13d. STREET AND NUMBER 4504 Banner Street
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Margaret M. Randall - Wife
18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute intoxication (ethyl alcohol) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-24-69
EXAMINER'S NAME (Type) John Kehoe MD		ADDRESS (Street, city, town or county) Riverdale, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-27-69	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City or Town) (County) (State) Prince George, Maryland
24. FUNERAL DIRECTOR John T. Rhines Co. Funeral Home		25a. REC'D BY REGISTRAR JUN 30 1969		25b. REGISTRAR'S SIGNATURE J. Charles Jones

1621

TO HOSPITAL C
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
45M 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> 08884 CERTIFICATE OF DEATH 08878 </div>										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
Jane			L			Reilly			10:15P	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 24 HRS.	
Female		White		01-17-16			53 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH:			
Md		U S A					Prince George's Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
Cheverly				Prince George's General Hospital				Housewife		Home
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
MD				Prince George's		Bowie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 20A Chestnut Ave
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Jacob S Seitz			Annie M. E. Reum							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. 577-18-0568		17. INFORMANT		Address		
						Emmett F. Reilly		Bowie, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of Lung & metastasis</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
6-29-69		Respiratory obstruction				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION				
White <input type="checkbox"/> Not while at work <input type="checkbox"/>						Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6-29, 1969, to 6-29, 1969, that (I) (we) last saw the deceased alive on 6-29-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Bahram Erfan M.D.								7-1-69		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
Bahram Erfan, M.D.				6001 Landover Rd, Cheverly, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		July 3, 1969		Holy Trinity Cemetery			Collington Pro Geo Md			
24. FUNERAL DIRECTOR				ADDRESS			25a. FILED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Md.			JUL 7 1969		Charles Judge	

3

11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or print)			First Dorothy			Middle E.			Last Rivera			2a. DATE OF DEATH Month 6 Day 27 Year 69			2b HOJR 1:40 A		
3 SEX Female			4 RACE White			5 DATE OF BIRTH 03-02-07			6 AGE (In years last birthday) 62 YRS			7 UNDER 1 YEAR MONTHS DAYS 			8 UNDER 24 HRS HOURS MIN 		
7a. BIRTHPLACE (State or foreign country) Md			7b. CITIZEN OF WHAT COUNTRY? U S A			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md								
10 CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b KIND OF BUSINESS OR INDUSTRY Home								
3a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE MD			13a CITY OR TOWN Prince Geo. Rogers Hts.			13b COUNTY Prince Geo.			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d STREET AND NUMBER 5010 - 53rd place					
14. FATHER'S NAME First Joseph A Middle Fortenbaugh Last 			15 MOTHER'S MAIDEN NAME First Dorothy Middle Hartman Last 														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no (or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 			17 INFORMANT Address Fernando L Rivera Hyattsville, Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYOCARDIAL INFARCTION												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 HRS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from June 26, 1969 , to June 27, 1969 , that (I) (we) last saw the deceased alive on June 26, 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE Benjamin S. Miller M.D.						DEGREE 			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 27 June 69					
22d PHYSICIAN'S NAME (Type) Benjamin S. Miller, M.D.						22e ADDRESS 3824 - 34th St. Mt. Rainier, MD.											
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE June 30, 1969			23c. NAME OF CEMETERY OR REPOSITORY Gate of Heaven			23d LOCATION (City or Town) (County) (State) Wheaton Montgomery Md.								
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a REC'D BY REGISTRAR DATE JUL 1 1969			25b REGISTRAR'S SIGNATURE Charles Judge								

1830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

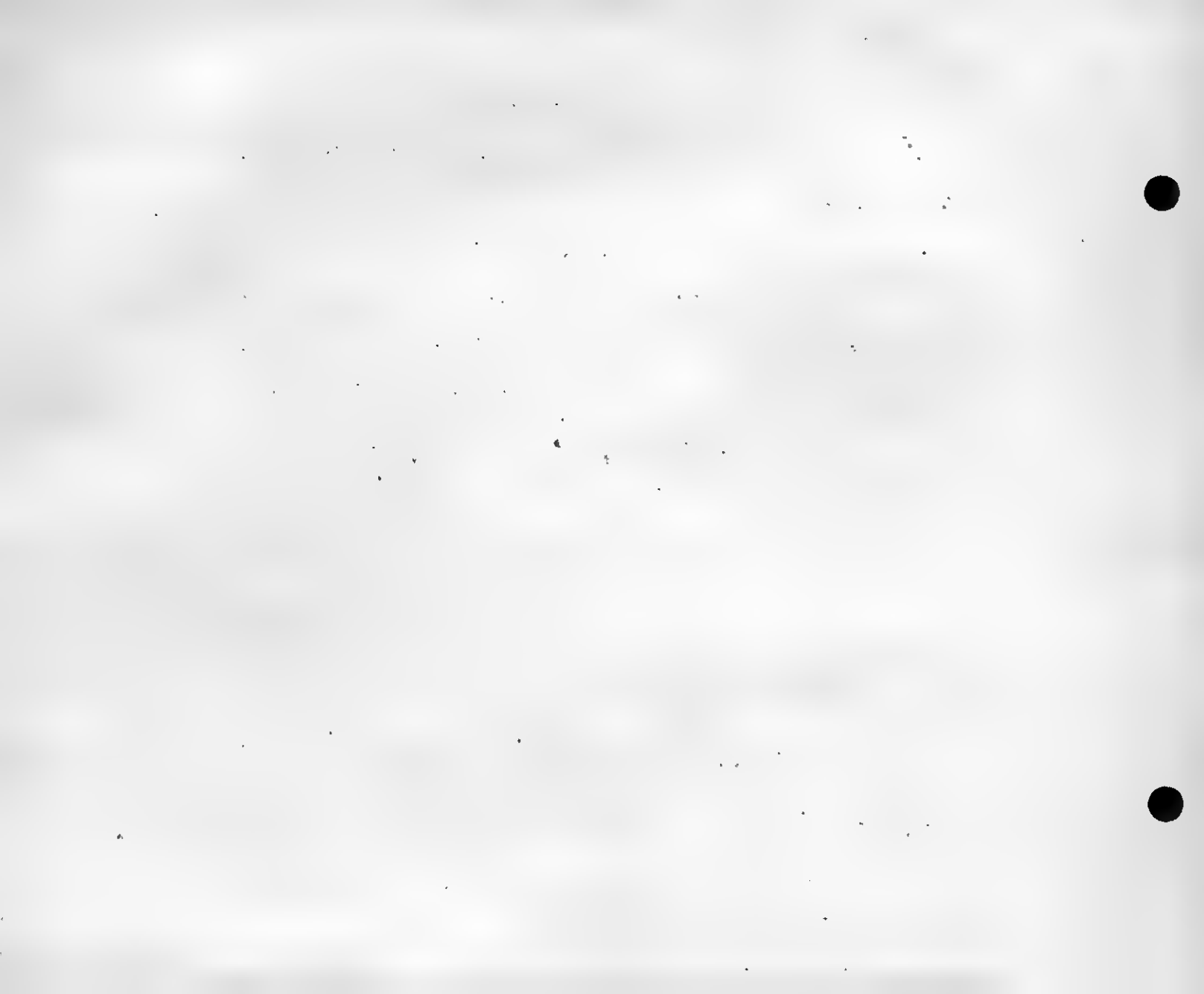
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08886

CERTIFICATE OF DEATH

08880

1 DECEASED-NAME (Type or print) MILDRED M. ROBISON			2a DATE OF DEATH Month JUNE Day 28 Year 1969			2b HOUR 9 P M					
3 SEX F		4 RACE N		5. DATE OF BIRTH MAY 17, 1899		6 AGE (In years last birthday) 70 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGE Md.					
10. CITY OR TOWN OF DEATH LAUREL			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 321 TALBOT AVE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY PRINCE GEO			13c CITY OR TOWN LAUREL		13d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 321 TALBOT AVE	
14 FATHER'S NAME First Middle Last FREDERICK NELSON			15 MOTHER'S MAIDEN NAME First Middle Last DAISY BUCKLEY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give year or dates of service)			16b SOCIAL SECURITY NO			17. INFORMANT Address KATHRYN GONZALES - A BOLE					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Terminal Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma of Ovary DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1954 , 19 June 28 , 19 69 , that (I) (we) last saw the deceased alive on June 28 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert C. Winfield, M.D.						DEGREE PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 28, 1969			
22d. PHYSICIAN'S NAME (Type) ROBERT C. WINFIELD						22e. ADDRESS Laurel, Maryland					
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL			23b. DATE 7/1/69			23c. NAME OF CEMETERY OR CREMATORY ST. MARYS CEM.			23d. LOCATION (City or Town) (County) (State) LAUREL PG MD		
24. FUNERAL DIRECTOR DONALDSON FUNERAL HOME						ADDRESS LAUREL MD		25a. REC'D BY REGISTRAR DATE JUL 3 1969		25b. REGISTRAR'S SIGNATURE Flavio Judge	



777X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

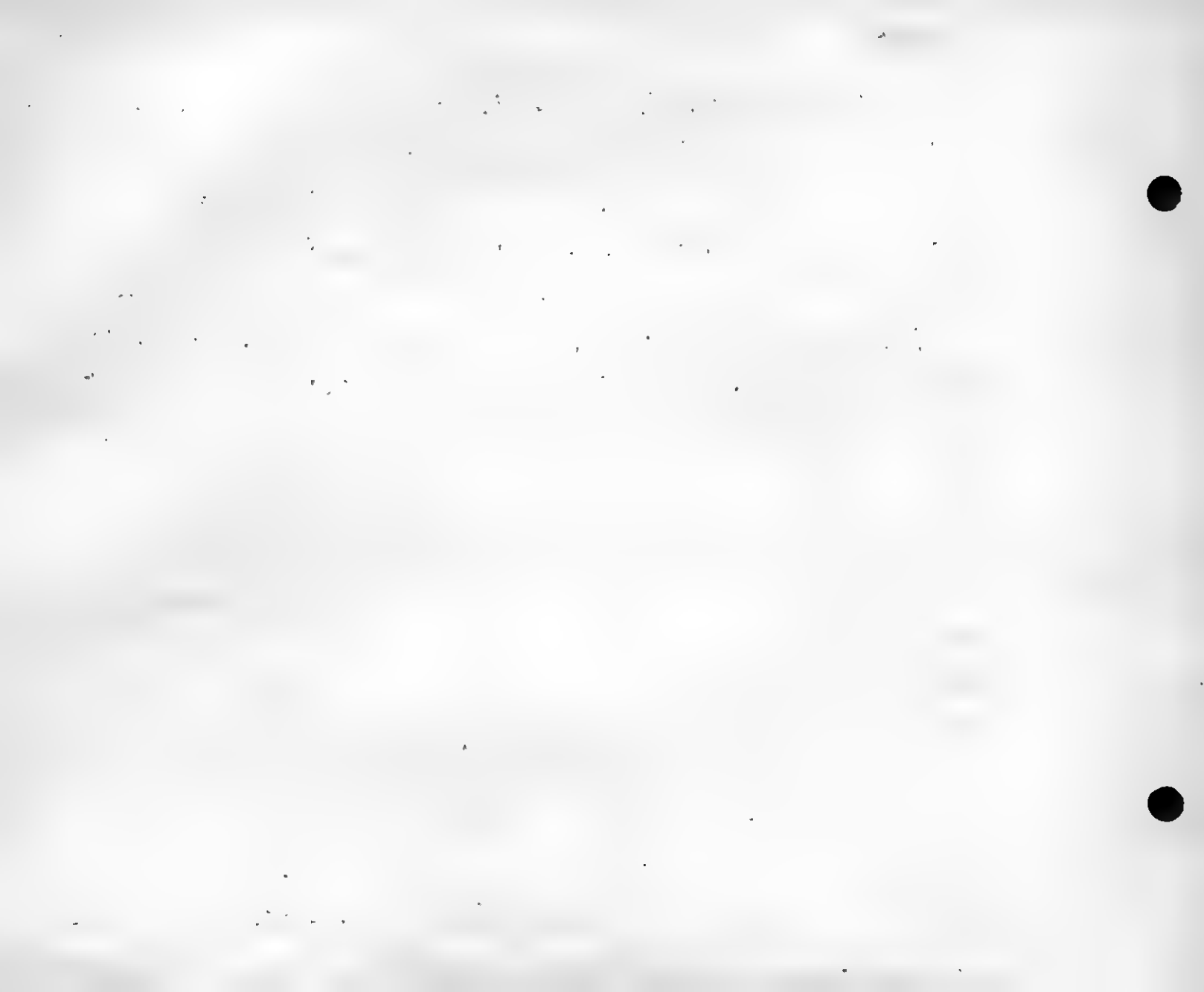
08887

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08881

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Steven Allen Rockland			2a. DATE OF DEATH Month 6 Day 15 Year 69			2b. HOUR 7:39 AM	
3 SEX male		4. RACE WHITE		5 DATE OF BIRTH 6/15/69		6 AGE (In years last birthday) YRS — MONTHS — DAYS —	
7a BIRTHPLACE (State or foreign country) MD		7b CITIZEN OF WHAT COUNTRY? Prince Georges		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10 CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE		12b KIND OF BUSINESS OR INDUSTRY NONE	
13a USUAL RESIDENCE (Where deceased lived, if institut on. Res dence before admission) STATE MD		13b COUNTY Prince George's		13c CITY OR TOWN Greenbelt		13e STREET AND NUMBER 227 Lakeside Drive	
14 FATHER'S NAME First Edward Middle Rockland Last Rockland		15. MOTHER'S MA DEN NAME First Carole Middle Gilbert Last Gilbert					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (link work) NO (If yes give year or dates of service)		16b SOCIAL SECURITY NO. NONE		17 INFORMANT Edward Rockland - Greenbelt, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Primum stivity DUE TO, OR AS A CONSEQUENCE OF (b) Primum stivity DUE TO, OR AS A CONSEQUENCE OF (c) Primum stivity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFF CE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6/15/69 , 19 69 to 6/15/69 , 19 69 , that (I) (we) last saw the deceased alive on 6/15/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				22c. DATE SIGNED 6/15/69			
22d. PHYSICIAN'S NAME (Type) F.E. MUMMICH				22e. ADDRESS #810 74th Ave			
23a. BURIAL OR CREMATION, REMOVAL (Specify)		23b. DATE 6/19/69		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cem.		23d. LOCATION (City or Town) (County) (State) Waynesboro, PA	
24 FUNERAL DIRECTOR A.G. Mummich		ADDRESS Greencastle, PA		25a. RECD BY REGISTRAR JUN 19 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



450X
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Film 3 414 7/1/69 11w 08888												Film 414 7-1-69 ams 08882	
1 DECEASED-NAME (Type or print) First Middle Last NELLIE M. SAYRE						2a DATE OF DEATH Month Day Year 6 19 69				2b HOUR 11:55 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH 05-18-85		6 AGE (In years last birthday) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country) IRELAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.							
10 CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.				12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY			
13a USUA. RES. DENCE (Where deceased lived if institution Residence before admission) STATE MD				13b COUNTY Prince George's		13c CITY OR TOWN Mitchellville		13d NSICE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Villa Rose Home Ave.			
14 FATHER'S NAME First Middle Last UNKNOWN				15 MOTHER'S MAIDEN NAME First Middle Last UNKNOWN				Address 178 RIDGEB RD.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) NO				16b SOCIAL SECURITY NO. NONE		17 INFORMANT MRS FRANCES HANER GREENBELT, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism? 450X DUE TO, OR AS A CONSEQUENCE OF Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF Fx of (rt) hip. 5 days APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fx (RT) Hip													
19a DATE OF OPERATION 6/17/69				19b CONDITION FOR WHICH OPERATION WAS PERFORMED Fx of RT Hip				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR AM Month Day Year PM June 15 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Pt fell in the Nursing Home							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) Nursing Home - Villa Rosa		21f LOCATION Street or RFD No City or Town County State Mitchellville P.G. Md.									
22a. I certify that (I) (this hospital) attended the deceased from 6/19, 1969, to 6/20, 1969, that (I) (we) last saw the deceased alive on 6/19/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b SIGNATURE G.H. Nader						DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 6/19/69			
22d. PHYSICIAN'S NAME (Type) G.H. NADER						22e ADDRESS Laurel, Maryland							
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 6-23-69		23c NAME OF CEMETERY OR CREMATORY Baltimore County		23d LOCATION (City or Town) (County) (State) Columbus Manor Maryland							
24. FUNERAL DIRECTOR W.W. C. Chambers Co. Riverdale, Md.						25a. REC'D BY REGISTRAR DATE JUN 23 1969		25b REGISTRAR'S SIGNATURE Phyllis A. Rudge					

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 23
7/1/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08883

1 DECEASED NAME (Type or Print) DONALD BRYAN SCOTT BUTLER		2a DATE KNOWN OF DEATH Mated <input type="checkbox"/> June 19 1969 Pronounced Dead <input type="checkbox"/> June 19 1969		2b HOUR 10:00 AM	
3 SEX M	4 RACE W	5 DATE OF BIRTH 13 SEPT. 1948	6 AGE (In years last birthday) 20 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) FLORIDA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges	
10 CITY OR TOWN OF DEATH CLINTON	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital street address) BASE Hosp Andrews A.F.		12a USUAL OCCUPATION (Kind of work done during last 12 months, if retired) US NAVY		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD		13b COUNTY ST. MARYS EX. PARK		13c CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER
14. FATHER'S NAME First Middle Last DONALD B. SCOTT SR			15 MOTHER'S MAIDEN NAME First Middle Last UNKNOWN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) APR. 1967-JUNE 1969		16b SOCIAL SECURITY NO. 214578990		17 INFORMANT ADDRESS NAVY FILES PATUXENT RIVER, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic Rupture of Heart DUE TO, OR AS A CONSEQUENCE OF with Atrial Pericarditis & Hemopericardium DUE TO, OR AS A CONSEQUENCE OF Automobile accident					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH not
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Head on collision	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, public building, etc.) Street		21f. LOCATION Street or RFD No City or Town County State Route 5 Clinton Pr Geo Md	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dayton O Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6-20-69	
EXAMINER'S NAME (Type) DAYTON O WATKINS		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE 6/21/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	
23d. LOCATION (City or Town) (County) (State) ANNAPOLIS, MARYLAND		25a. REC'D BY REGISTRAR JUN 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MD.					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08890

08884

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Sadie		V.	Scott	2a. DATE KNOWN OF DEATH		6-18-69	19	11	10am	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 24 HRS	8. MONTHS	9. DAYS	10. HOURS	11. MIN	2c. DATE PRONOUNCED DEAD	2d. HOUR
Female	White	8-30-1883	85 YRS	6	18	69	19	11	30am	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
Kansas		U.S.A.		Prince George's						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Riverdale		6300 Riverdale Road		Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Prince George's		Riverdale				6811 Riverdale Road		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Calvin				Krah	Emily J. Hynes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		578-36-2312A		Miss Lois Scott-(Above address)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										minutes
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John Kehoe MD		Riverdale Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED
EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		6-18-69
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		6/20/69		Ft. Lincoln Cem.		Cedar Manor, Md.				
24. FUNERAL DIRECTOR		Nalley's Funeral Home Inc.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				St. Painer, Maryland		JUN 23 1969		Charles Judge		

MEDICAL CERTIFICATE ON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies 1, 2 and 3 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR			
Mary E. Shank						6 - 11 - 69		10 25 AM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR			
Female		Wht.		4 - 11 - 94		75 YRS		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Myersville, Md.		U.S.A.				Prince Georges Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Clinton, Md.			Pineview Gardens Healthcare Center			Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LIMITS?		13e STREET AND NUMBER		
Maryland			Prince Geo.		Hillcrest Hgts		YES <input type="checkbox"/> NO <input type="checkbox"/>		2504 Colebrook Drive		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Carlton			P		Shank	Sarah					Palmer
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT					
						Blanche Shank 2405 Fairlawn St Hillcrest Hgts					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Occlusion</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>myocardial heart disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)			21f. LOCATION		City or Town County State			
						Street or R.F.D. No					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>69</u> , to <u>6/11</u> , 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/11</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)					
Alfred R. Lapidus						ALFRED R. LAPIDUS, MD					
22e. ADDRESS			22f. ADDRESS			CLINTON, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			6-11-1969		Washington National		Suitland PG Maryland				
24. FUNERAL DIRECTOR						25a. REC'D BY REG. STRAR		25b. REG. STRAR'S SIGNATURE			
Robert E. Wilhelm Funeral Home						JUN 16 1969		Charles Judge			
4308 Suitland Road Suitland Maryland											

777X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR 3P M		
Baby Henrietta G. M. V.			Shannon			June 8 1969		3P		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		06-08-69		YRS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
USA						Prince George's Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, MISS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			Prince George's		Clinton				6104 Woodlnd Lane	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
						Maureen Theresa Shanran				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Premature labor										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from June 8, 1969, to June 8, 1969, that (I) (we) last saw the deceased alive on June 8, 1969, and that in (our) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Cremation		6-14-69		Prince George's Gen. Hosp.		Cheverly, Pr. George's, Md.				
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Harry W. Penn, Jr., Administrator						JUN 19 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08893

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08887

1. DECEASED-NAME (Type or print) First Middle Last Edna M. Shewell			2a. DATE OF DEATH Month Day Year 6 20 69			2b. HOUR 9:15 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9/9/93		6. AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Camden, N.J.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md			
10. CITY OR TOWN OF DEATH Glenn Dale, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. U.S. OCCUPATION (Kind of work done during most of working life even if retired) Retired Book Binder		12b. KIND OF BUSINESS OR INDUSTRY Printing co			
13a. USUAL RESIDENCE (Where deceased lived, if not at home at time of death) STATE no		13b. COUNTY Wash., D.C.		13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1734 Mass., Ave. S. E.	
14. FATHER'S NAME First Middle Last John L. Dungan			15. MOTHER'S MAIDEN NAME First Middle Last Mamie Jordan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO 578 12 7474A		17. INFORMANT Decedent		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to aspiration of food 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis with arteriosclerotic heart disease and chronic brain syndrome years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (he) this hospital attended the deceased from <u>1/10/</u> , 19 <u>69</u> , to <u>6/20/</u> , 19 <u>69</u> , that (he) (we) last saw the deceased alive on <u>6/20/</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (not) view the body after death.									
22b. SIGNATURE <i>Moe Weiss</i>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/20/69		
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.					22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 24, 1969		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE JUN 25 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. The original should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
08889		Item #5, Film 7/7/69 km		08888					
1 DECEASED NAME (Type or print) First Middle Last Lillian Shirkey				2a. DATE OF DEATH Month Day Year June 20 1969		2b. HOUR 1:05A M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH 07-17-17 1916		6 AGE (In years last birthday) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) West Va		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md.			
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Housewife		12b K ND OF BUSINESS OR INDUSTRY home			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b COUNTY Prince George's		13c CITY OR TOWN Bowie		13d INSIDE CITY, LIM TS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2304 Hanover Place	
14. FATHER'S NAME First Middle Last Lamuel Ridgeway				15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Gregory					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16b SOCIAL SECURITY NO 235 54 8636		17 INFORMANT Address Julia L Walker					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction due to severe coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) Not while at work		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a INJURY OCCURRED While at work		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 6/16 , 19 69 , to 6/20 , 19 69 , that (I) (we) last saw the deceased alive on 6/20 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Leonard Appel, M.D.				22c DATE SIGNED		22d PHYSICIAN'S NAME (Type) Leonard Appel, M.D.			
22e ADDRESS Sage Lane, Bowie, M D.				22f. ADDRESS					
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE June 24, 1969		23c NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d LOCATION (City or Town) (County) (State) Lewisburg West Va		23e REGISTRAR'S SIGNATURE Charles Judge	
24 FUNERAL DIRECTOR F. Gasch's Sons		24b ADDRESS Hyattsville, Md.		25a REC'D BY REGISTRAR JUN 23 1969		25b REGISTRAR'S SIGNATURE			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08895

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08889

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
George Washington Shirley					DATE KNOWN OF DEATH		6	26	19	9:30am
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		Month	Day	Year
Male	White	1-13-1905	64	MONTHS	DAYS	DATE PRONOUNCED DEAD		6	26	19
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
Virginia		USA				Prince George's				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Laurel		709 Park Ave		Carpenters Helper		Construction				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET AND NUMBER		
Maryland		Prince George's		Laurel		YES <input type="checkbox"/> NO <input type="checkbox"/>		709 Park Ave		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
George Washington Shirley					Cendrella Wells					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
NO		NONE		Elsie M. Shirley		709 Park Ave. Laurel, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min. <u>unknown</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED		
John Kehoe MD		Riverdale, Md.						6-26-69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6-28-1969		Lewinsville Presby, Ch.		McLean, Virginia				
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Charles D. Bange		2847 Wilson Blvd.		JUN 30 1969		[Signature]				
Ives Funeral Home, Inc.		Arlington, Va.								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Co-signed by the Registrar, Prince George's County, Md.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
088896											
08890											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
Benjamin Edwin Short						June 1 1969			4:30 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
male			cauc			March 2, 1882			87 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Missouri			USA						Prince George's County Md		
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			
Riverdale, Md.				Eugene Leland Mem. Hosp.				Postal Supervisor Government			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN			
Maryland				Prince George				Hyattsville			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
James Perry Short				Amanda Crews				4315 Gallatin Street			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT Address			
unknown				492-32-3629				Edwin E. Short Same as #13			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) _____ (b) _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Oct 5, 1961, to June 1, 1969, that (I) (we) last saw the deceased alive on May 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L W MALIN MD						22c. DATE SIGNED June 1, 1969		22d. PHYSICIAN'S NAME (Type) L W MALIN MD			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			6/4/69			Ft. Lincoln			Colmar Manor P.G. Md.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
F. Saech's Sons Hyattsville, Md						JUN 5 1969			Chambers		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, on in any event, within 72 hours after death.

4109

08897

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08891

1. DECEASED NAME (Type or print) CHRISTEN Christian		First CHRISTEN Middle SKJOLDBORG Skjogdborg		2a. DATE OF DEATH Month June Day 16 Year 1969		2b. HOUR 5:05 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH OCT 2, 1893		6. AGE (In years lost birthday) 75 YRS	
7a. BIRTHPLACE (State or foreign country) DENMARK		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MAINTENANCE ENG.		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Bladensburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 5428 Varnum Street		14. FATHER'S NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN		15. MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown No		16b. SOCIAL SECURITY NO 081213024		17. INFORMANT ANNE M. SKJOLDBORG		Address Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (b) Atherosclerosis, Generalized DUE TO, OR AS A CONSEQUENCE OF (c) 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either: notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 1957 to June 1969 , that (I) (we) last saw the deceased alive on May 28, 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE William D. Rosson				22c. DATE SIGNED 6/18/69			
22d. PHYSICIAN'S NAME (Type) William D. Rosson, M.D.				22e. ADDRESS Prince George's Gen. Hosp.			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE JUNE 19, 1969		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD				25a. REC'D BY REGISTRAR JUN 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
088998					08892								
Item 41, 5, 13b, 16b, 23d. Film 444 7/5/69					CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
Alva			A/		Edward		Smith		June 18, 1969		12:05 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		05-12-08			61 YRS		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH							
Kentucky		U.S.A.		XX		Prince George's							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. K NO OF BUSINESS OR INDUSTRY							
Cheverly		Prince Goerg'es Gen. Hosp.		Electrical Engineer									
13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS DE CITY LIM 157		13e. STREET AND NUMBER					
MD		Prince George's		Prakoma Pk.		YES <input type="checkbox"/> NO <input type="checkbox"/>		7801 Wildwood Drive					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Luther		M. Smith		Edna E. Murphy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give way or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT									
Yes		WW #2		309-07-0397		Margaret F. Smith		7801 Wildwood Dr. Pk.					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal Carcinomatosis													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, wh ch gave rise to immediate cause (a) stating the underlying cause lost.													
(b) Undetermined													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(Enter nature of injury in Part 1 or Part 2, Item 18.)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		Street or RFD No		City or Town		County		State	
While <input type="checkbox"/> Not while <input type="checkbox"/>		(AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.											
22a. I certify that (I) (this hospital) attended the deceased from May 16, 1969 to June 12, 1969, that (I) (we) last saw the deceased alive on June 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DATE SIGNED											
Ronald S. Fleischer		6-18-69											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
RONALD S. FLEISCHER		1411 RIGGS RD											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
		June 23, 1969		Hebron Cemetery		Huntsville		Bullitt Co		Kentucky			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Arthur Waters		JUN 23 1969		W. W. Judge									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08899

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08893

1. DECEASED NAME (Type or print)		First Nora	Middle J.	Last Smith	2a. DATE OF DEATH Month June Day 3 Year 1969		2b. HOUR 11:30 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 04-24-07		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			MD
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Landover Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1600 Annapolis Avenue	
14. FATHER'S NAME First J Middle M Last Mann		15. MOTHER'S M A DEN NAME First Lusk							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Doris M. Lawless Address 3516 Pumphrey Dr Forest-					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis								APPROXIMATE TIME BETWEEN ONSET AND DEATH 13 days 2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC			21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 27 May , 1969, to 3 June , 1969, that (I) (we) last saw the deceased alive on 3 June , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John M. Hutelings M.D. DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6-3-69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 7315 Landover Rd. Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-6-1969		23c. NAME OF CEMETERY OR CREMATORY Lusk Cemetery			23d. LOCATION (City or Town) (County) (State) Beartown West Virginia		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home					25a. REC'D BY REGISTRAR JUN 10 1969		25b. REGISTRAR'S SIGNATURE W. Charles Judge		
4308 Suitland Road Suitland Maryland									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08900

08894

1. DECEASED-NAME (Type or print) First William Middle A Last Smith			2a. DATE OF DEATH Month June Day 25 Year 1969			2b. HOUR 4P M			
3. SEX Male		4 RACE White		5. DATE OF BIRTH Oct 12, 1898		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Printer			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4003 Nicholson St.	
14. FATHER'S NAME First Middle Last ? ? ?			15. MOTHER'S MAIDEN NAME First Middle Last ? ? ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO WW1		17. INFORMANT Address Ella Marie Smith Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 weeks</u> <u>12 days</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>53</u> , to <u>June 25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/25/69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Gordon W. Kelley MD.</u>				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>6/26/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Gordon W. Kelley</u>				22e. ADDRESS <u>6124 41st Ave, Hyattsville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 30, 1969		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR JUN 30 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08901

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08895

1. DECEASED-NAME (Type or print) Bessie Lee Sondheimer			2a. DATE OF DEATH Month 6 Day 12 Year 1969			2b. HOUR 12:50 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-20-83		6. AGE (in years last birthday) 86 YRS	
7a. BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Hya. Hsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Theopolis		15. MOTHER'S MAIDEN NAME Edith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/> (If yes give war and dates of service)			
16b. SOCIAL SECURITY NO. 518-05-0542		17. INFORMANT Hospital Record -		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF General arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 8 , 19 69 , to June 12 , 19 69 , that (I) (we) last saw the deceased alive on June 12 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L W Malin		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-12-69	
22d. PHYSICIAN'S NAME (Type) L W MALIN MD		22e. ADDRESS Riverdale, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-16-1969		23c. NAME OF CEMETERY OR CREMATORY Shenwood		23d. LOCATION (City or Town) (State) Waldorf, Md	
24. FUNERAL DIRECTOR McIntyre Co		25a. REC'D BY REGISTRAR 131-11th St. S.E. Wash. D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE JUN 16 1969	

FOR STATE HEALTH DEPT.

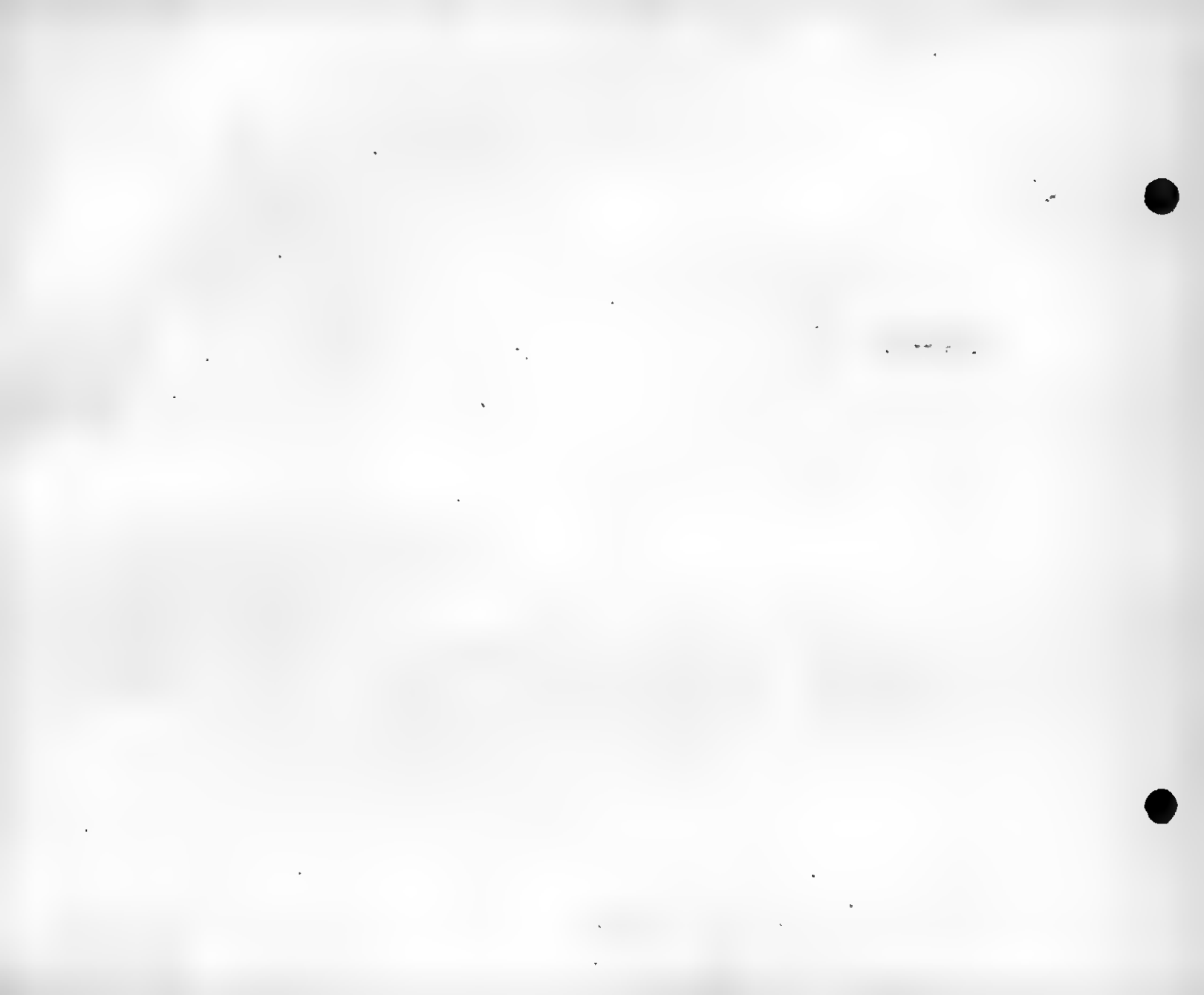
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil within 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH			
James		Russell		SOUDER		Month 6 Day 12 Year 19 69		2b HOUR 1:25 PM			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	7 UNDER 1 YEAR		8 UNDER 24 HRS		2c DATE PRONOUNCED DEAD		
M	W	28 Aug. 1937		31 YRS	MONTHS DAYS		HOURS MIN		Month 6 Day 12 Year 19 69		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA		Prince George				Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Prince George		Leland Hosp				owner-operator station					
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Md		Prince George		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1012 Harrison Drive			
14 FATHER'S NAME			First			Middle			Last		
Harace			Souders			Freda			Dreslaine		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			(If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS		
						Dolores Souders - Phone					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure									Min		
4123 DUE TO, OR AS A CONSEQUENCE OF											
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Arteriosclerotic heart disease									Unknown		
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County		
									State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale				M.D.		22b. DATE SIGNED			
EXAMINER'S NAME (Type)						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		6-13-69			
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)			
Burial		6/15/69		Emmanuel Cem		Seagoville		Md			
24 FUNERAL DIRECTOR		ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Canadian Funeral Home		Laurel				JUN 17 1969		Charles Judge			

4-1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
08903		CERTIFICATE OF DEATH								08897		
1 DECEASED NAME (Type or print) First Middle Last Walter C. Spriggs						2a. DATE OF DEATH Month Day Year June 27 1969			2b. HOUR 11:40pM			
3 SEX male		4 RACE colored		5 DATE OF BIRTH Feb. 14, 1889			6 AGE (In years last birthday) 80 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Md		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.						
10 CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General				12a USCA. OCCUPATION (Kind of work done during most of working life, even if retired) Laborer			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b. COUNTY Prince George's		13c CITY OR TOWN Cheverly		13d INSIDE CITY LIM? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 708 59th Place		
14 FATHER'S NAME First Middle Last B. Spriggs				15 MOTHER'S M.A.D.N. NAME First Middle Last Emily Deal								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) (If yes give war or dates of service) No				16b SOCIAL SECURITY NO -		17 INFORMANT Address Coty Spriggs 725-61st Ave -						
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, severe</u> 513X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung abscess, lep upper lobe</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (H) (this hospital) attended the deceased from <u>May 22</u> , 19 <u>69</u> , to <u>June 27</u> , 19 <u>69</u> , that (H) (we) last saw the deceased alive on <u>June 27</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.												
22b SIGNATURE U. Lee						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED June 30, 1969				
22d PHYSICIAN'S NAME (Type) U. Lee, M.D.						22e. ADDRESS Prince George's General Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-2-69		23c. NAME OF CEMETERY OR CREMATORY Harmeny		23d. LOCATION (City or Town) (County) (State) Highland Park Md.						
24. FUNERAL DIRECTOR H.P. Washington						25a. REC'D BY REGISTRAR JUL 3 1969		25b. REGISTRAR'S SIGNATURE Richard Judge				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Lost	2a DATE OF DEATH Month Day Year			2b HOUR
Charles			W.	Steinecker	June 8 1969			11:30 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER YEAR MONTHS DAYS HOURS MIN	
Male		White		08-28-84		84 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pa		USA				Prince George's Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George's Gen. Hosp.			Unknown		Unknown	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
PA.			Franklin		YES <input type="checkbox"/> NO <input type="checkbox"/>		310 11th Street		
14 FATHER'S NAME			First	Middle	Lost	15 MOTHER'S MAIDEN NAME First Middle Lost			
Unknown						Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
Unknown			unknown		Mrs. Jean McFalls, Landover Hills, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL FAILURE</u>									<u>2 hours</u>
1541 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADENOCARCINOMA OF RECTUM</u>									<u>6 months</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>HAD NO DESIRE TO LIVE</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
5/6/69		ADENOCARCINOMA OF RECTUM		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5/12/69		Evisceration							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. no City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 27, 1969</u> , to <u>JUNE 8, 1969</u> , that (I) (we) last saw the deceased alive on <u>JUNE 8, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
<u>Saul Schwartzbach</u>								6/9/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Saul Schwartzbach				5426 27th St. N. W. Washington, D. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Removal		June 10, 1969				Franklin, Pennsylvania			
24. FUNERAL DIRECTOR				25a. REGISTRY		25b. REGISTRAR'S SIGNATURE			
Lanham Funeral Home				JUN 11 1969		[Signature]			
Lanham, Maryland 20801				DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10398

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1969</u>		2b. HOUR <u>7:00</u> A M
3. SEX Male				4. RACE Negro	5. DATE OF BIRTH 06-22-69		6. AGE (in years last birthday) YRS.
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George's Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Palmer Pk.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME William		First Stevenson		15. MOTHER'S MAIDEN NAME Agnes		First Stevenson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Premature Labor</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Premature rupture of membranes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>							
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <u>June 22, 1969</u> , to <u>June 22, 1969</u> , that (2) (we) lost saw the deceased alive on <u>June 22, 1969</u> , and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Pablo S. Falo</u>		22c. DATE SIGNED <u>June 27, 1969</u>		22d. PHYSICIAN'S NAME (Type) <u>Pablo S. Falo, M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>7-26-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prince George's Gen. Hosp.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cheverly, Pr. George's, Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr.</u>		ADDRESS <u></u>		25a. REC'D BY REGISTRAR <u>JUL 30 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) ELSIE M STOUT			2a. DATE OF DEATH 6 Month 13 Day 69 Year			2b. HOUR 6:30 PM			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH 2/4/85		6 AGE (In years last birthday) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGES Md			
10 CITY OR TOWN OF DEATH ADELPHI, MD.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MANOR CARE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived (admission) STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7719 GREENWOOD AVE	
14. FATHER'S NAME First Middle Last ALPHA EUGENE CARVER			15. MOTHER'S MAIDEN NAME First Middle Last CLARA BELL HINSON.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT RUTH OSBORN		Address TAKOMA PR. MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH: WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mo.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT? WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1968 , 19 June 13 , 19 69 , that (I) (we) last saw the deceased alive on June 13 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Janet A. [Signature]				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED June 13, 69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 5717 Canell Ave Takoma Park Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE JUNE 17, 1969		23c. NAME OF CEMETERY OR CREMATORY Fairfax City		23d. LOCATION (City or town) (County) (State) Fairfax 60 - Fairfax VA.			
24. FUNERAL DIRECTOR Walter D. [Signature]				25a. REC'D BY REGISTRAR 2574 Canell St NW		25b. REGISTRAR'S SIGNATURE [Signature]		DATE JUN 19 1969	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First Anna		Middle C.		Last Sullivan		2a. DATE OF DEATH Month June Day 5 Year 1969		2b. HOUR 5:45 AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 10-08-1900		6 AGE (in years last birthday) 68 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's		Md			
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George's Gen. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home			
13a. USUAL RESIDENCE (Where deceased lived, if instit in Residence before admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Kentland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3008 76th Avenue			
14. FATHER'S NAME First Michael Middle Quinn Last		15. MOTHER'S MAIDEN NAME First Mary Middle McMahon Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO no		17 INFORMANT Mrs. Helen M. Adams, Same as blk 13e							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of orary - Terminal</u> <u>1530</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis to Lungs.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from June 4, 1969, to June 5, 1969, that (I) (we) last saw the deceased alive on June 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Luis Bentolila</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED June 5, 1969					
22d. PHYSICIAN'S NAME (Type) Luis Bentolila, M.D.		22e. ADDRESS Prince George's General Hospital									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.					
24. FUNERAL DIRECTOR <u>Lanham Funeral Home, Lanham, Md.</u>		ADDRESS <u>1 Robert H. Burt</u>		25a. REC'D BY REGISTRAR JUN 10 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>					

4/21

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08908										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08901									
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
(Frank) Francis Gregory Swann										June 7, 1969										7:30 PM									
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS														
male			white			12-2-93			25 YRS			MONTHS			DAYS														
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED			NEVER MARRIED			9. COUNTY OF DEATH																	
Maryland			U.S.A.			WIDOWED			DIVORCED			Prince Georges Co.			Md														
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY																				
Clinton			Pine View Gardens			Carpenter			Building																				
13a USUAL RESIDENCE (Where deceased lived or admission) STATE			13b. COUNTY			13c CITY OR TOWN			3d INSIDE CITY LIMITS?			13e STREET AND NUMBER																	
md.			Charles			La Plata Hughesville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																				
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME																										
Jack			Swann			Ida			Parker																				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17. INFORMANT			Address																				
No			218-07-7127-A			Son			Joseph R. Swann			La Plata, Md																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a)										58 months																			
417 Cerebral Hemorrhage																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										2-3 yrs.																			
(b) Cerebrovascular Hypertension																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c) Cerebral senile syndrome																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
Hypertensive Prostate																													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. ACCIDENT WAS UNDERLYING			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year																										
			P.M. 19																										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION			Street or R.F.D. No.			City or Town			County														
While <input type="checkbox"/> Not while <input type="checkbox"/>																													
at work <input type="checkbox"/> at work <input type="checkbox"/>																													
22a I certify that (I) (this hospital) attended the deceased from 8/17, 1968, to 6/7, 1969, that (I) (we) last saw the deceased alive on 6/2, 1969, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
Alfred P. Lapin, M.D.										6/7/69																			
22d PHYSICIAN'S NAME (Type)										22e ADDRESS																			
ALFRED P. LAPIN, M.D.										CLINTON, MD.																			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			(County)			(State)														
Burial			6/10/69			St. Mary's Cemetery			Bryantown, Md.																				
24 FUNERAL DIRECTOR										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE									
Archibald Lunsell Home, Inc. La Plata, Md.										JUN 17 1969										Charles Judge									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in paragraph Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08902			
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Clarence Albert Sweeney								ESTIMATED <input checked="" type="checkbox"/> 6 6 1969					11:00 am
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years from birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	12 June 1907		61 YRS		MONTHS DAYS		HOURS MIN		Month 6 Day 7 Year 1969		11:00 am	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
Maryland		U.S.A.				Prince George							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George Hospital		Upper Marlboro									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md.		Prince George		Upper Marlboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 2, Box 20070, Brown Station Rd.					
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
Greenburry		Sweeney		UNK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
no				LeRoy Sweeney (son)		8904 Wayne Dr							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Heart failure												Minutes	
DUE TO, OR AS A CONSEQUENCE OF Calcific aortic stenosis and													
(b) Hypertensive heart disease												Years	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)										6-8-69			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		6/11/69		St Barnabas Cemetery		Leeland Maryland							
24. FUNERAL DIRECTOR Lee Funeral Home				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
300 4th St n.e. Wash D.C.								DATE JUN 12 1969		J. Carlos Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Classified with Mr. Examiner - Dr. J. F. K. K. K.

Item 5 & Item 1 Film 444 7/22/69 kk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08910	
1 DECEASED NAME (Type or print) Cornelius Raphael Sweeney		2a DATE OF DEATH June 25 1969		2b HOUR 7:45 PM	
3 SEX Male	4 RACE White	5. DATE OF BIRTH 12/8/1888	6. AGE (In years last birthday) 80	7. UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) Freeland, Pa.	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince George		
10. CITY OR TOWN OF DEATH Adelphi	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10407 Truxton Road, Adelphi		12a. USUAL OCCUPATION (Kind of work done) Police Officer		12b. KIND OF BUSINESS OR INDUSTRY C. J. J.
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) Maryland	13b. COUNTY Prince George	13c. CITY OR TOWN Adelphi	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 10407 Truxton Road,	
14. FATHER'S NAME James J. Sweeney	15. MOTHER'S MAIDEN NAME Mary J. Raislin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Unknown	16b. SOCIAL SECURITY NO. 189-18-8772	17. INFORMANT Eleanor R. Sweeney Address 10407 Truxton Rd. Adelphi			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 hours 3 years 15 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY 19 HOUR A.M. Month Day Year	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that U (this hospital) attended the deceased from Feb. 27 , 19 69 , to Jun 25 , 19 69 , that U (we) last saw the deceased alive on Mar. 30 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, U (we) did (did not) view the body after death.					
22b. SIGNATURE R. D. Bauer, M.D.	DEGREE D. Bauer, M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 6-25-69		
22d. PHYSICIAN'S NAME (Type) R. D. Bauer, M.D.	22e. ADDRESS 2513 Buck Lodge Rd. Adelphi, Md. P.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 28, 1969	23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	23d. LOCATION (City or Town) Hanover Township, Wilkes-Barre	(State) Pa.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc., 8434 Ga., Ave., SPS		25a. REC'D BY REGISTRAR JUN 30 1969	25b. REGISTRAR'S SIGNATURE William Judge		

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

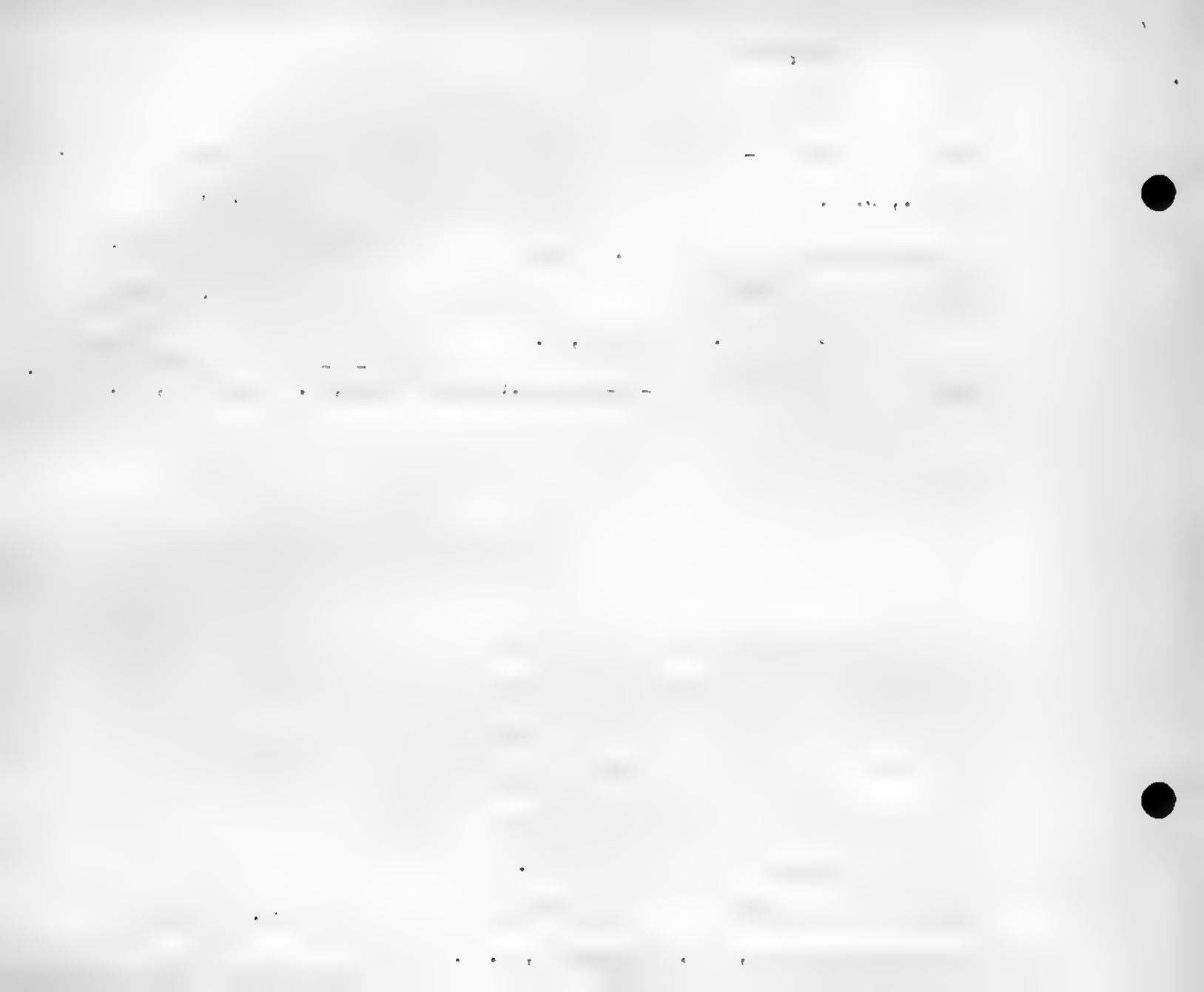
<div style="display: flex; justify-content: space-between;"> 08911 MARYLAND STATE DEPARTMENT OF HEALTH 08904 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print) <i>James P. Taylor</i>			First Middle Last			2c. DATE OF DEATH 6 Month 2 Day 69 Year			2b. HOUR 8 P. M.		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>May 10, 1894</i>			6. AGE (In years last birthday) <i>85</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Mt. Erie</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i> Md.					
10. CITY OR TOWN OF DEATH <i>Greenbelt</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Greenbelt Convalescent</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution) STATE <i>md</i>		13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1402 Moffett Rd S.W.</i>			
14. FATHER'S NAME <i>Wheeler</i>			First Middle Last			15. MOTHER'S MAIDEN NAME <i>Mattie Keizer</i>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>			16b. SOCIAL SECURITY NO. <i>33 2-073026</i>			17. INFORMANT <i>W. Joseph Williams</i>			Address <i>1402 Moffett Rd S.W.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>										<i>Immediate</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>										<i>15 years</i>	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Parkinson's Disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>9-29</i> , 19 <i>67</i> , to <i>6-2</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5-31</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <i>Burton A. Johnson M.D.</i>						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6-2-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Burton A. Johnson</i>						22e. ADDRESS <i>67 Eldrid Drive, Silver Spring</i>					
23a. BURIAL CREMATION REMOVAL (Specify) <i>Buried</i>		23b. DATE <i>June 6, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Hope Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Champaign, Illinois</i>				
24. FUNERAL DIRECTOR <i>C. Glen Carter 8434 Georgia Avenue</i> <i>Warner E. Humphrey, Inc., Silver Spring, Md.</i>						25. DATED BY REGISTRAR <i>JUN 10 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1 Film 411 7/15/69 kk										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										10402																																																											
1. DECEASED-NAME (Type or Print)										First Middle Last										2a. DATE KNOWN OF DEATH										2b. HOUR																																																											
Robert										N. Taylor, Jr.										Month Day Year										19 PM M																																																											
3 SEX										4 RACE										5. DATE OF BIRTH										6 AGE (In years last birthday)										7. DATE PRONOUNCED DEAD										2d. HOUR																																							
Male										White										5-16-1932										37 YRS										Month Day Year										19 11:30am																																							
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																																	
Wash., D. C.										USA										Prince George's																																																																					
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																											
Hyattsville										8307 14th. Avenue										Broker										Stock																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																																																	
Maryland										Prince George's										Hyattsville										YES <input type="checkbox"/> NO <input type="checkbox"/>										8307 14th. Avenue																																																	
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																																																											
Robert										N. Taylor, Sr.										Kathryn										Joyce																																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b. SOCIAL SECURITY NO										17. INFORMANT (brother-in-law)										ADDRESS																																																											
Yes										1952-1954										579-42-3080										Mr. Laurence Boido, Jr.										Rockville, Md.																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										LIVER FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
7/12										DUE TO, OR AS A CONSEQUENCE OF										Cirrhosis of liver																																																																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b)										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(c)																																																																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																																					
										HOUR A.M. P.M.										19																																																																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No										City or Town										County										State																																							
22a. I certify that I took charge of the remains described above, held on										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:										Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																					
ACTUAL SIGNATURE										John Kehoe MD										Riverdale, Md.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										ASS STANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										ADDRESS (Street, city, town, or county)										22b. DATE SIGNED										7-10-69									
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town)										(County)										(State)																																							
Burial										7/11/69										Cedar Hill Cemetery										Suitland, Maryland																																																											
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REG. STRAR										25b. REGISTRAR'S SIGNATURE																																																											
Joseph Gawler's Sons, Inc.										Washington, D. C.										DATE JUL 14 1969										William J. Jones																																																											



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08913

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08905

1 DECEASED NAME (Type or Print) First <u>ARTHUR</u> Middle <u>HENRY</u> Last <u>THOMAS</u>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-18-69 192:16am		2b. HOUR	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 7-29-1897	6 AGE (In years last birthday) 71 YRS.	7c. DATE PRONOUNCED DEAD 6 Month 18 Day 69 Year 193:23am M	2d. HOUR
7a. BIRTHPLACE (State or foreign country) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Prince George's Md.		10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital	
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) OWNER-OPERATOR		12b KIND OF BUSINESS OR INDUSTRY RESTAURANT		13a USUAL RESIDENCE (Where deceased lived, i. institution; Residence before admission) STATE Maryland	
13b. COUNTY Prince George's		13c CITY OR TOWN Laurel		13d INSIDE CITY (If not YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 909 4th. Street		14. FATHER'S NAME First <u>SAMUEL</u> Middle <u>THOMAS</u> Last <u>ROSLINA</u>		15. MOTHER'S MAIDEN NAME First <u>ROSLINA</u> Middle <u>WILKINS</u> Last <u>WILKINS</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO WWW1-WWW2		17 INFORMANT MARGARET THOMAS - ABOVE	
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Rupture of abdominal aortic aneurysm</u> <u>4412</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Kehoe</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6-18-69	
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ADDRESS (Street, city, town, or county)			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE 6/23/69		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATL CEM.	
24. FUNERAL DIRECTOR Danneleean Funeral Home, Laurel, Md.		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD		25a. REC'D BY REGISTRAR JUN 23 1969	
		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															Film 15 7/30/69 kk				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															08914 08906				
1 DECEASED NAME (Type or Print) <i>Johanna Paula Traiber</i>										2a DATE KNOWN OF DEATH <i>ESTI</i> Month <i>6</i> Day <i>20</i> Year <i>1969</i>			2b HOUR <i>M</i>						
3 SEX <i>F</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>Dec 10 1906</i>		6 AGE (in years last birthday) <i>62</i> YRS		7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		8 UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>		2c DATE PRONOUNCED DEAD Month <i>June</i> Day <i>20</i> Year <i>1969</i>			2d HOUR <i>5 PM</i>				
7a BIRTHPLACE (State or foreign country) <i>Germany</i>				7b C.T.ZEN OF WHAT COUNTRY? <i>USA</i>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH <i>Prince Georges</i> Md							
10 CITY OR TOWN OF DEATH <i>Cheverly</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince Georges General Hosp</i>				12a USIA OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>				12b KIND OF BUSINESS OR INDUSTRY <i>Home</i>							
13a USIA RESIDENCE (Where deceased lived, if institution residence, before admission) STATE <i>Md</i>				13b COUNTY <i>Prince Georges</i>				13c CITY OR TOWN <i>Beltsville</i>		13d INS OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>2231 BELTSVILLE RD - 71 ave</i>							
14. FATHER'S NAME First <i>Fischer</i> Middle <i>Fischer</i> Last <i>Fischer</i>					15 MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16b SOCIAL SECURITY NO <i>171-11-1111</i>				17 INFORMANT <i>Dolores Traiber</i>				ADDRESS <i>4212 71 ave Beltsville</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>															<i>few minutes</i>				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart disease</i>															<i>1 1/2 yrs</i>				
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic nephritis</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b TIME OF INJURY Month, Day, Year <i>1969</i> HOUR A.M. <i>19</i> P.M.					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f LOCATION Street or R.F.D. No <i>71 ave</i> City or Town <i>Beltsville</i> County <i>Prince Georges</i> State <i>Md</i>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Dayton Watkins</i> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b DATE SIGNED <i>6-21-69</i>									
EXAMINER'S NAME (Type) <i>DAYTON D WATKINS</i>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b DATE <i>June 24, 1969</i>					23c NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>					23d LOCATION (City or Town) <i>Colmar Manor</i> (County) <i>Pro Geo Md.</i> (State)				
24. FUNERAL DIRECTOR <i>F. Gasch's Sons Hyattsville, Md.</i>										25a REC'D BY REGISTRAR <i>JUN 25 1969</i>					25b REGISTRAR'S SIGNATURE <i>James Judge</i>				



FOR STATE HEALTH DEPT.

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08915

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08907

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-11-69 197:00am M				2b. HOUR
Dorothy E. Trilling										
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH			2d. DATE PRONOUNCED DEAD Month 6 Day 11 Year 69 9:16am M
Female	White	12-5-1906	62 YRS.	O.C.	U.S.A.		Prince George's			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USJA. OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital			Housewife			At home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Prince George's Mt. Rainier						2400 Queens Chapel Rd.	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S M.A.D.E.N. NAME			First	Middle
John E. Haldsmith						Julia A. Peske				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS	
None			None			William J. Trilling			Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										minutes
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										over 10 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED	
John Kehoe MD			Riverdale, Md.			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			6-12-69	
DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			6-14-69		Washington National		Suitland Maryland			
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. W. Chambers			517-115 H. S. E.			JUN 17 1969		J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08916

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08918

1. DECEASED-NAME (Type or print)		First	Last		2a. DATE OF DEATH			2b. HOUR	
Tito		ALBERTO		Tulio		Month June Day 3 Year 1969			5:30 PM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Phillipino		UU-UU-UU 12-13-39		29 YRS.		MONTHS 5 DAYS 20		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PHILIPPINE IS.		PHILIPPINE				Prince George's Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp.		TECHNICAL CONSULTANT		PAPER BAG CO.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		Prince George's		Mt. Rainier				3724 36th Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
ARTEMIO		TULIO		JOSEFA B.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		NONE		BENJAMIN TULIO		3703 PERRY ST. MT. RAINIER MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Laryngeal Obstruction									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Severe Edema - probably allergic Swelling									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				Street or R.F.D. No					
22a. I certify that (this hospital) attended the deceased from June 1, 1969, to June 3, 1969, that (X) (we) lost saw the deceased alive on June 3, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Edwin J. Jensen, M.D.		6-5-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Edwin J. Jensen, M.D.		Prince George's General Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		6/16/69		MANILA PHILIPPINE IS.		MANILA PHILIPPINE ISLAND			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W.W. Chambers & Sons, 1400 N. W. Washington		JUN 6 1969		Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MICHIGAN DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2c. DATE OF DEATH Month Day Year		2b. HOUR	
Walter		Wallace						June 17 1969		8:35P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		Negro		Dec. 5, 1939		29 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md.		U.S.A.				Prince George's				Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince George's Gen. Hosp.									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS OR CITY, AT IS?		13e. STREET AND NUMBER			
MD		Howard		Laurel		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. 1 Box 27			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
McDonald		Wallace						Estella		Snell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>Diffused granulomatous lesions involving the</u>											
DUE TO, OR AS A CONSEQUENCE OF whole gastro-intestinal tract, omentum,											
(c) <u>mesentery, spleen and liver</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from <u>June 14, 1969</u> , to <u>June 17, 1969</u> , that (X) (we) last saw the deceased alive on <u>June 17, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d) (d.d not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED					
S. V. Nair, M.D.						June 18, 1969					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
		Prince George's Gen. Hosp.									
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6/21/69		Mt. Zion Cemetery		Bacantown Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert L. Swankin		Rockville		JUN 25 1969		Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
08918										
08910										
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Fred			Washington			June 20 1969		2:00AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		Negro		08-18-21		47 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Chesler, Md.		U.S.A.				Prince George's		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USJA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George's Gen. Hosp.								
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) STATE			13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			PG		Upper Marlboro		YES <input type="checkbox"/> NO <input type="checkbox"/>		West Failure Street	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
James H. Washington			Ruth A. Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
					Elenora Washington		Bryantown, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock										
398 X DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost										
(b) Rheumatic heart disease & Atrial Fibrillation										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Congestive Heart Failure										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										
Anuria										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (X) (this hospital) attended the deceased from June 18, 19 1969 June 20, 19 69 that (X) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
P.C. Xavier, M.D.			Prince George's Gen. Hosp.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/24/69		St. Peter's Ch. Cem.		Waldorf, Chas. Co. Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Martell Adams			Aguasco, Md.			JUN 26 1969		Charles Judge		

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) MARTHA MARIE WATERS			2a. DATE KNOWN OF ESTI DEATH MATED June 19 1969			2b. HOUR M		
3. SEX F	4. RACE C	5. DATE OF BIRTH Sept 23 1919	6. AGE (In years last birthday) 49	7. UNDER 1 YEAR MONTHS 0 DAYS 0	8. IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD June 19 1969		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George		
10. CITY OR TOWN OF DEATH upper marlboro		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince Geo Gen Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admision) STATE Md		13b. COUNTY Pr Geo upper marlboro		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4354 Osborne Rd		
14. FATHER'S NAME First Henry Middle Ford Last 			15. MOTHER'S M.A.DEN NAME First anne Middle Pinkney Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO 			17. INFORMANT 4354 Osborne Rd Joe Waters upper marlboro Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Inhalation of toxic DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Substance - Propane gas few minutes DJE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subject inhaled Gas from oven				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or RFD No 4354 City or Town upper marlboro County State Md				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dayton Watkins			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 6-20-69		
EXAMINER'S NAME (Type) DAYTON D WATKINS			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county) 					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-25-69		23c. NAME OF CEMETERY OR CREMATORY Resurrection		23d. LOCATION (City or Town) (County) (State) Clinton, Md.		
24. FUNERAL DIRECTOR Rollins Funeral Home Inc. 4339- Hunt Pl. N.E.				25a. REC'D BY REGISTRAR JUN 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

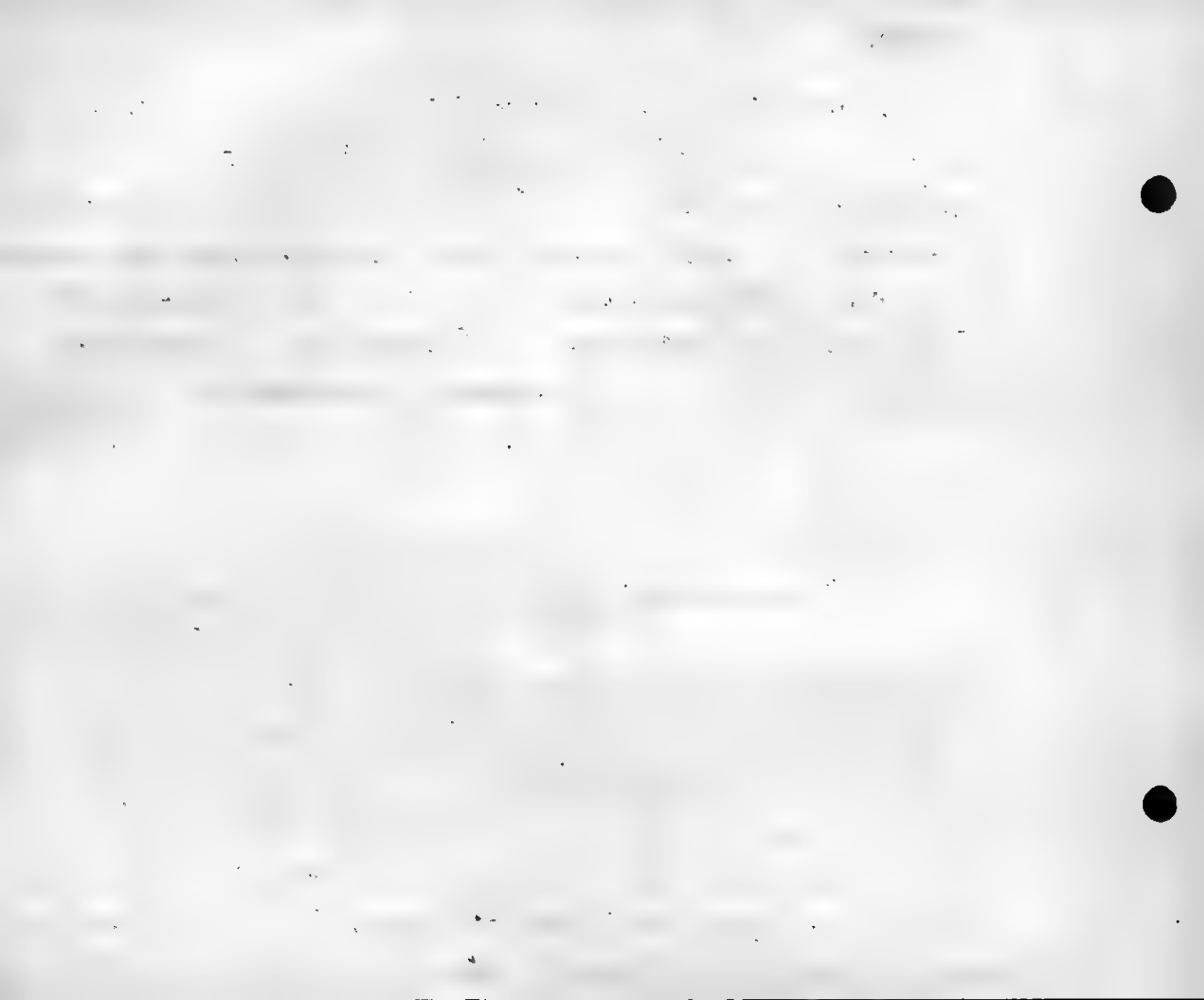
08920

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08912

1 DECEASED-NAME (Type or print) WARNER W. WATERS			2a. DATE OF DEATH Month JUNE Day 1 Year 1969			2b. HOUR M	
3 SEX M		4. RACE W		5. DATE OF BIRTH FEB. 2, 1897		6. AGE (In years last birthday) 72 YRS	
7a. BIRTHPLACE (State or foreign country) A.A.C. CO. MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.	
10 CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 323 GORMAN AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) OWNER-TRAINER		12b. KIND OF BUSINESS OR INDUSTRY RACE HORSES	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY, J.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last THOMAS I WATERS		15. MOTHER'S MAIDEN NAME First Middle Last FLORENCE G. WELSH		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO		17 INFORMANT Address WARNER S. WATERS, SR.					
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Previous cerebrovascular accident?							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/13 , 19 69 , to 6/2 , 19 69 , that (I) (we) lost the deceased alive on 6/2 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harris		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/2/69	
22d. PHYSICIAN'S NAME (Type) Harris		22e. ADDRESS 3001 S. HANOVER ST. BALTO 30					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/4/69		23c. NAME OF CEMETERY OR CREMATORY ST PETERS CEM		23d. LOCATION (City or Town) (County) (State) FT. GEO. G. MEADE, MD	
24. FUNERAL DIRECTOR Donaedian Funeral Home, Laurel		ADDRESS		25a. REC'D BY REGISTRAR JUN 10 1969		25b. REGISTRAR'S SIGNATURE William J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08921

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 566 Film 414 7/1/69 kk

CERTIFICATE OF DEATH

08913

1 DECEASED NAME (Type or print) EARL N. WEBB			2a DATE OF DEATH June 10, 1969			2b HOUR 1:30 AM					
3 SEX Male		4 RACE White		5 DATE OF BIRTH 21, 1917 January 17, 1923		6 AGE (In years last birthday) 48 52 YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Tenn.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.					
10 CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Engineer, Tech.			12b KIND OF BUSINESS OR INDUSTRY Government		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY P. G.			13c CITY OR TOWN Lanham		13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6874 Riverdale Road	
14 FATHER'S NAME First Middle Last John W. Webb			15 MOTHER'S MAIDEN NAME First Middle Last Willie Hanes								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes			16b SOCIAL SECURITY NO WW 11 413-05-3257			17 INFORMANT Address Edna T. Webb Same as # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive atherosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 3 yrs									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none											
19a DATE OF OPERATION none			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 9, 1969 to June 9, 1969 , that (I) (we) last saw the deceased alive on June 9, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Raymond J. Terrafranca						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED June 10 1969			
22d PHYSICIAN'S NAME (Type) Raymond J. Terrafranca M. D.						22e ADDRESS #8 Barney Circle S. E. Wash, D. C.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE June 13, 1969			23c NAME OF CEMETERY OR CREMATORY Highland Mor. Cemetery			23d LOCATION (City or Town) (County) (State) Knoxville, Knox Tennessee		
24 FUNERAL DIRECTOR F. Gasch						25a REC'D BY REGISTRAR JUN 13 1969			25b REGISTRAR'S SIGNATURE James J. Judge		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08922

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08914

1 DECEASED NAME (Type or Print) First Middle Last William F. Wellington Jr.			2a DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 06 20 69 10:50			2b HOUR 10:50		
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH 05-29-52	6 AGE (In years) 17 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year June 20 1969		
7a BIRTHPLACE (State or foreign country) Riverdale		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges County, Md.		
10 CITY OR TOWN OF DEATH Riverdale		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Mem. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Prince Georges		13c CITY OR TOWN Adelphi		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET AND NUMBER 10117 Chickadee Lane		
14. FATHER'S NAME First Middle Last William F. Wellington Sr.			15 MOTHER'S MAIDEN NAME First Middle Last Marie D. Green					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) NO		16b SOCIAL SECURITY NO NO		17 INFORMANT William F. Wellington Jr.			ADDRESS 10117 Chickadee Lane Adelphi Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MULTIPLE INJURIES TO HEAD & ABDOMEN DUE TO, OR AS A CONSEQUENCE OF (c) AUTOMOBILE ACCIDENT								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 2 DAYS 2 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION no			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year June 18 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Auto Collision				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or R.F.D. No. City or Town County State High Point High School Laurel Prince Georges Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dayton Watkins			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 6-20-69		
EXAMINER'S NAME (Type) DAYTON O WATKINS			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) 254 Carroll St. N.T.								
23a BURIAL, CREMATION, REMOVAL (Specify) burial		23b DATE June 24-1969		23c NAME OF CEMETERY OR CREMATORY St. Joseph's		23d LOCATION (City or Town) (County) (State) Shaw's Creek - Md.		
24 FUNERAL DIRECTOR Arthur Waters		25a REC'D BY REGISTRAR DATE JUN 23 1969		25b REGISTRAR'S SIGNATURE John J. Judge				

4442

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

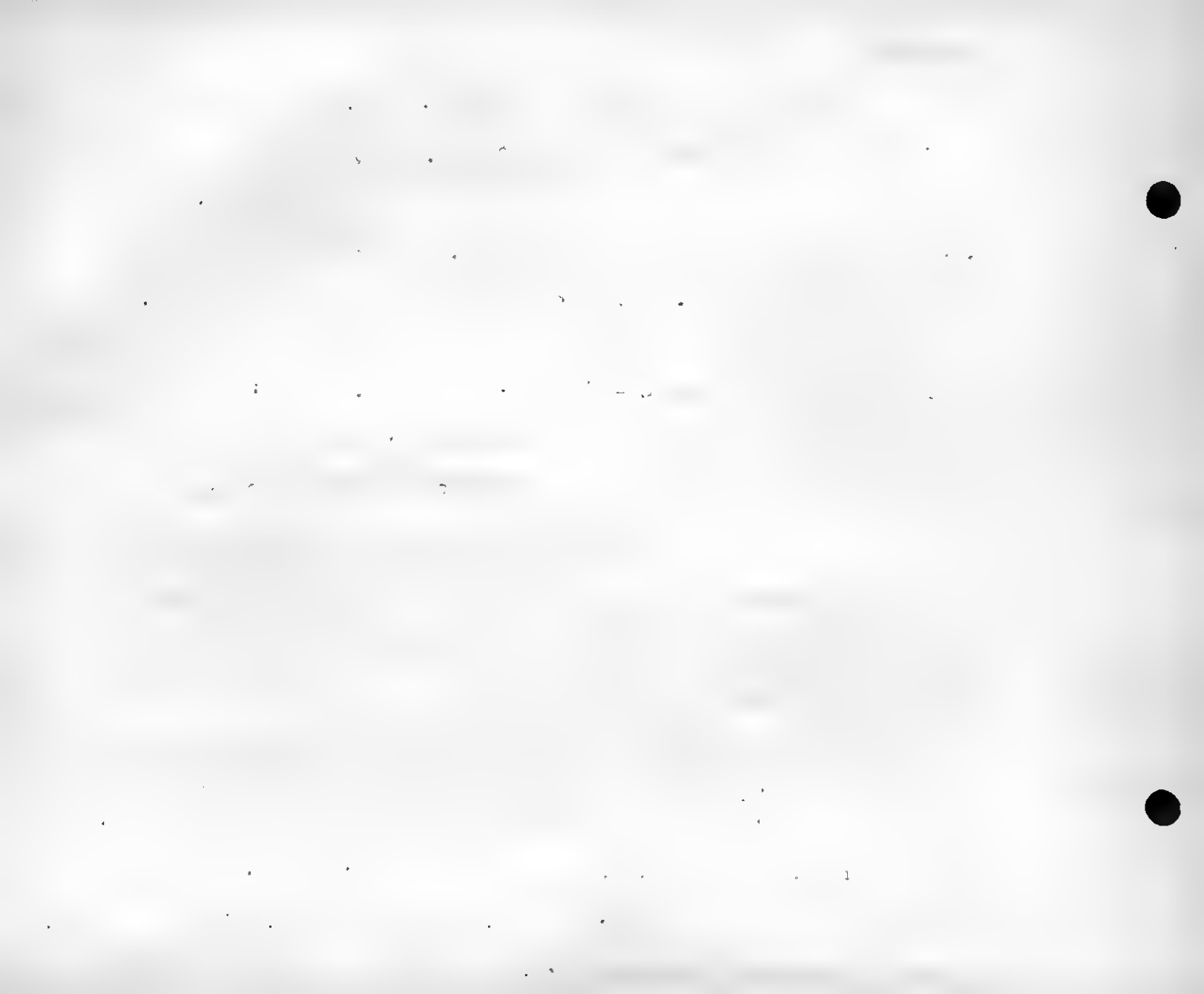
13

08923

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08915

1 DECEASED-NAME (Type or print)		First Julia	Middle C	Last WESTWOOD	2a DATE OF DEATH Month 15 Day 1969 Year		2b HOUR 3:50 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2 Sept., 1897		6 AGE (In years last birthday) 71 YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Greenbelt		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 20 Crescent Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c CITY OR TOWN Greenbelt		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 20 Crescent Rd.
14. FATHER'S NAME First Middle Last Jesse J. Cone		15. MOTHER'S MAIDEN NAME First Middle Last Julia Pugh						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO. (If yes give war or dates of service) 444-03-6043		17. INFORMANT Address Husband: Mr. Samuel Westwood				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ 444.2 DUE TO, OR AS A CONSEQUENCE OF _____ Mesenteric thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause _____ (b) _____ Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Unknown								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 8 February, 1969, to 15 June, 1969, that (I) (we) last saw the deceased alive on 20 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Medical Examiner, Dr. Kehoe notified								
22b. SIGNATURE Carl J. Houmann				DEGREE M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 15 June, 1969
22d. PHYSICIAN'S NAME (Type) Carl J. Houmann, M. D.				22e. ADDRESS 4404 Queensbury Rd., Riverdale, Md.				
23a. BURIAL... CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-18-69		23c NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d LOCATION (City or Town) (County) (State) Thomasville Ga.		
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a REC'D BY REGISTRAR JUN 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
08924											
08916											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR	
Sophie		ANN		White				6 Month 26 Day 69 Year		1030 A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.	
Female		White		5-25-84		85 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Virginia		USA				Prince George				Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Riverdale		Eugene Leland Memorial		HOUSEWIFE		HOMEMAKER					
3a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
D.C.		V		Washington				215 Constitution Ave., N.E.			
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
John		Gutteridge						Margaret A. Wilkerson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or Unknown) (if yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address					
NO		578-68-888		Patient and Medical Records		BLADENSBURG MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY										ONE WEEK	
IMMEDIATE CAUSE (a)											
45X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
GEN. SENILE CHANGES											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 14 JUNE 1969, to present, that (I) (we) last saw the deceased alive on 25 JUNE 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		C. J. Houmann		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		26 JUNE 1969	
22d. PHYSICIAN'S NAME (Type)		C. J. HOUMANN M.D.		22e. ADDRESS		RIVERDALE MD.					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		JUNE 30, 1969		FORT LINCOLN CEMETERY		COLMAR MAROIS GEORGETOWN MD.					
24. FUNERAL DIRECTOR		W. W. Chambers to Riverdale, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
				DATE JUL 2 1969		Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08925

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08917

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Betty			V.	Williams	Month June 1 Day 1969 Year		11P M	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female	White		March 31, 1987		82 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
VIRGINIA		U.S.				Prince George's Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George's Gen. Hosp.		HOUSEWIFE		Security Division		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
MD		Prince George's		Cheverly		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5457 Madison Way
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
EDGAR				WARFIELD	ALICE DONAIE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		
NO				578123988		KENNETH L. WILLIAMS 5204 WOOD AV BURTOWN, MD		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction - Cardiac Arrest								3 days
4109 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
(b) Atherosclerotic Heart Disease								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
Intentional obstruction by chess in sleep								
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>								
22a. I certify that (I) (this hospital) attended the deceased from 5-6, 1969, to 6-1, 1969, that (I) (we) last saw the deceased alive on 6-1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
Donald C. Edgren								6-2-69
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
DONALD C. EDGREN				6201 Greenbelt Rd College Park, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		5 JUNE 1969		WASHINGTON, NATIONAL		SUITLAND, MARYLAND		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
W. W. Chambers Co. Riverdale, Md.						JUN 6 1969		Charles Judge

08926

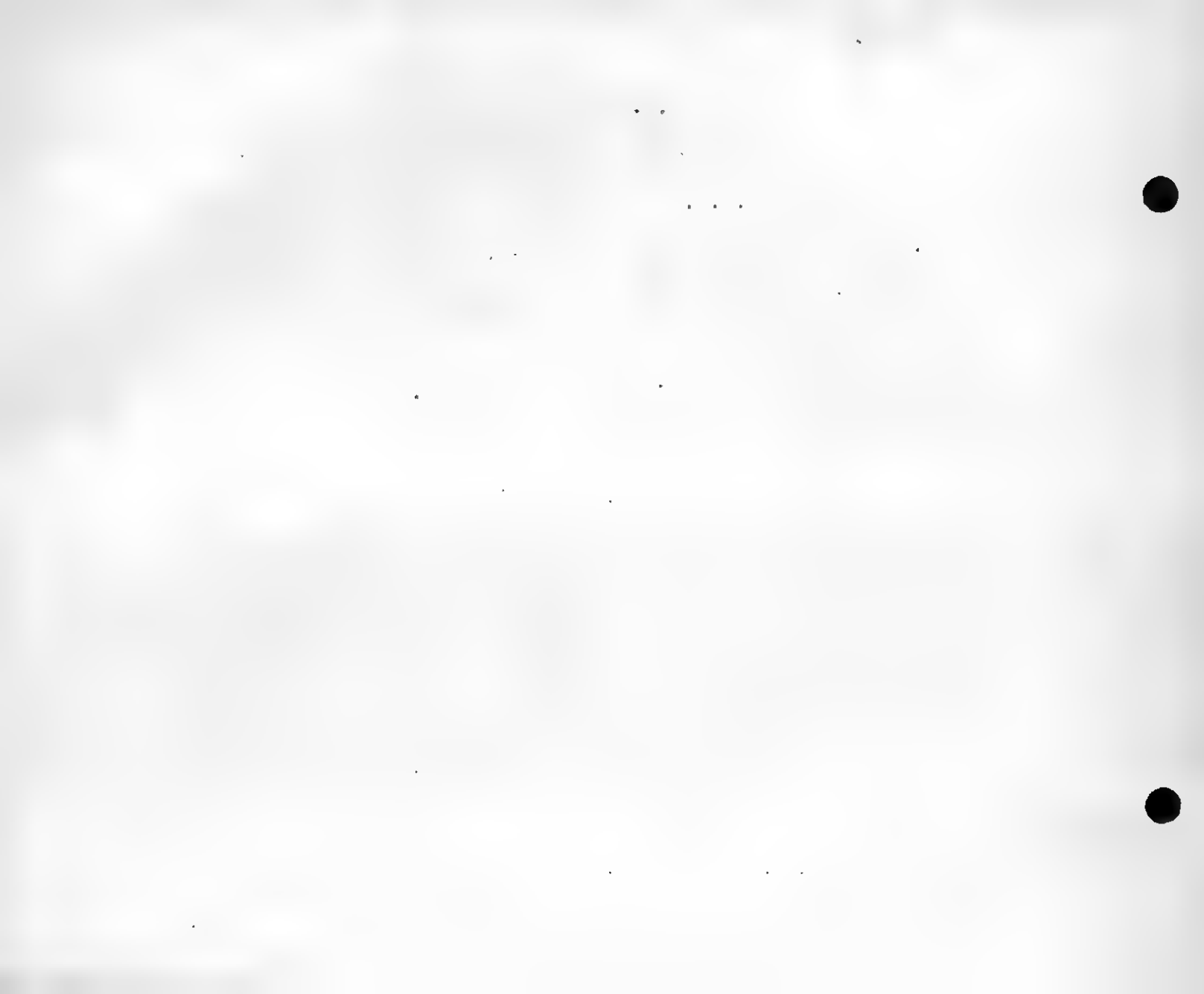
CERTIFICATE OF DEATH

08918

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Amelia		S.T.		Windmiller	June 17 1969			7:30 PM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR		8 UNDER 24 HRS
Female	White		06-02-86		83 YRS.		MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
New York	U.S.A.				Prince George's			Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George's Gen. Hosp.		Housewife			own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
MD		Prince George's		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4708 Rocky Spring Lane	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
Albert			Schilgn		Agnes			Rosenow	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
no		147 22 6844		Joseph A. Lopez		Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Massive right cerebral hemorrhage</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Broncho-pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION		Street or R.F.D. No.		City or Town	County
White <input type="checkbox"/> Not while at work <input type="checkbox"/>									State
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1968</u> , to <u>June 17, 1969</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>June 17, 1969</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.									
22b SIGNATURE		22c DATE SIGNED							
<u>Leonard P. Appel, M.D.</u>		June 18 1969							
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
Leonard P. Appel, M.D.		3231 Superior Lane		Bowie, MD					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		6/20/69		Oak Hill Cemetery		Nyack		Rockland	N Y
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons		Hyattsville, Md.		JUN 20 1969		<u>William J. Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



4339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or print)			First Aubrey			Middle Lemuel			Last Windsor			2a DATE OF DEATH Month June 18 1969			2b. HOUR 3:16 PM		
3 SEX Male			4 RACE White			5. DATE OF BIRTH 01-06-92			6. AGE (In years lost birthday) 77 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Prince George's Md								
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George's Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during usual working life, even if retired) Tobacco Farming			12b. KIND OF BUSINESS OR INDUSTRY Own Farm								
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b. COUNTY Prince George's			13c. CITY OR TOWN Mitchellville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Box 11110, Mt. Oak Road, Mitchellville					
14 FATHER'S NAME John			First Albert			Middle Windsor			15 MOTHER'S MAIDEN NAME Mary Violet			First Garner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			(If yes give war or dates of service) --			16b. SOC. A. SECURITY NO			17 INFORMANT James A. Windsor-Rd., Mitchellville, Md								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thromboses</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>bronchopneumonia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)											
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1969</u> , to <u>June 18, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 18, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Don B. Cameron</u>			DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>June 19, 1969</u>								
22d. PHYSICIAN'S NAME (Type) Don B. Cameron, M. D.			22e. ADDRESS 3503 Perry St., Mt. Rainier, Maryland:														
23a. BURIAL, CREMATION REMOVAL (Specify) Burial			23b. DATE 6/21/69			23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery			23d. LOCATION (City or Town) (County) (State) Forestville Pr. Geo Md.								
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md. 20870			ADDRESS			25a. RECD BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08928

CERTIFICATE OF DEATH

10425

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Baby Male Wittgartener						Month	Day	Year	10:30 PM		
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years last b rthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male		White		June 23, 1969			YRS		MONTHS	DAYS	HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
MD		USA				Prince George's					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.								
13a. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD			Prince George's			Seabrook		YES <input type="checkbox"/> NO <input type="checkbox"/>		9323 Wellington St.	
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Daniel			Wittgartener			Frances			Arline Croonan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT Address					
NO											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) Prematurity 1600 grams											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) atelectasis neomatorum											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC)				21f. LOCATION Street or R.F.D. No City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 6-23-1969 to 6-24-1969, that (I) (we) last saw the deceased alive on 6-24-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Patrick A. Reardon, M.D.											
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
						9430 Lanham-Severn Road-Seabrook, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		F. C. (County)		(State)	
		7-11-69		Prince George's General		Cheverly					
24. FUNERAL DIRECTOR						ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Harry W. Penn, Jr. - Adm.								JUL 15 1969			
								DATE			

1537

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08929		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08920							
1. DECEASED-NAME (Type or print) First Middle Last IDA WROBLE						2a. DATE OF DEATH 6 Month 17 Day 69 Year		2b. HOUR 11:30 PM					
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 12 FEB 20		6. AGE (In years) 69 birthday YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.							
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAF HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK TYPIST		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE NEW YORK		13b. COUNTY SCHENECTADY		13c. CITY OR TOWN SCHENECTADY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1030 PARK AVE					
14. FATHER'S NAME First Middle Last WILLIAM KARLAN		15. MOTHER'S MAIDEN NAME First Middle Last ANTOINETTE ARNOWSKUS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO						16b. SOCIAL SECURITY NO. 065141267		17. INFORMANT Stanley Wroble Oxon Hill Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> 155.1 DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CHOLANGIOCARCINOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 7 MONTHS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>15 JUNE 1969</u> , to <u>17 JUNE 1969</u> , that (I) (we) lost saw the deceased alive on <u>17 JUNE 1969</u> and that in (my) (our) apinial death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Edward A. Farber</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>17 June 69</u>									
22d. PHYSICIAN'S NAME (Type) EDWARD FARBER CAPT USAF MC		22e. ADDRESS MALCOLM GROW USAFHOBBS ANDREWS AFB											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-21-69		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS		23d. LOCATION (City or Town) (County) (State) ROTTERDAM N.Y.							
24. FUNERAL DIRECTOR W.W. CHAMBERS 511-11 th ST. S.E.				25a. REC'D BY REGISTRAR DATE JUN 18 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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08930

CERTIFICATE OF DEATH

08922

1. DECEASED NAME (Type or print) <i>Gertrude R. Young</i>		First Middle Last		2a. DATE OF DEATH Month <i>25</i> Day <i>1969</i> Year		2b. HOUR <i>3:01</i> PM	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>8/25/1882</i>		6. AGE (In years lost, birthday) <i>86 yrs.</i>	
7a. BIRTHPLACE (State or foreign country) <i>Minnesota</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Pr. Geo.</i>	
10. CITY OR TOWN OF DEATH <i>Lanham</i>		11. NAME OF HOSPITAL OR INSTITUTE (Give street address) <i>Magnolia Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Ret.-U.S. Govt.</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>		13b. CITY <i>Pr. Geo.</i>		13c. CITY OR TOWN <i>Colmar</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>Charles</i> Middle <i>T.</i> Last <i>Edwards</i>		15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>M.</i> Last <i>McAndrews</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-46-1181</i>		17. INFORMANT Address <i>Patricia Darling - above address</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Perforating ulcer</i> <i>5901</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>phlebotomy</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> <i>16 min</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 25, 1969</i> , to <i>June 25, 1969</i> , that (I) (we) lost saw the deceased alive on <i>June 25, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles J. Taylor</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6/25/69</i>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/30/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Wash., D.C.</i>	
24. FUNERAL DIRECTOR <i>Valley's Funeral Home Inc.</i>				25a. REC'D BY REGISTRAR <i>JUL 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Taylor</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

NE 920

Year	1990	1991	1992	1993	1994	1995
1990	1.0	1.0	1.0	1.0	1.0	1.0
1991	1.0	1.0	1.0	1.0	1.0	1.0
1992	1.0	1.0	1.0	1.0	1.0	1.0
1993	1.0	1.0	1.0	1.0	1.0	1.0
1994	1.0	1.0	1.0	1.0	1.0	1.0
1995	1.0	1.0	1.0	1.0	1.0	1.0